Chris Steller

From: Finnegan, Melissa (MDH) <melissa.finnegan@state.mn.us>
Sent: Friday, March 1, 2019 1:23 PM
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Cc: Thimjon, Lisa (MDH); Chris Steller; Andrea Todd-Harlin; Pat McQuillan; Anna Burke; Joe Durheim; Chris McCall
Subject: 2019 Adverse Health Events Report
Attachments: 2019 Adverse Health Events.pdf

Good afternoon,

I'm pleased to share with the 2019 Report on Adverse Health Events. This report provides an overview of events reported under Minnesota's Adverse Health Event Reporting law from October 2017 to October 2018. All hospitals and licensed surgical centers in Minnesota must report to MDH any time one of 20 "events" occurs. These events include things like serious falls, wrong site surgeries, and suicides.

Please let me know if you have any questions or if you would like to discuss this further. Thanks,

Melissa Finnegan
Director of Legislative Relations | Executive Office

Minnesota Department of Health
Office: 651-201-5805

Adverse Health Events in Minnesota

15TH ANNUAL PUBLIC REPORT

MARCH 2019

DEPARTMENT OF HEALTH

Adverse Health Events in Minnesota
Annual Report |March 2019

Minnesota Department of Health
Division of Health Policy
P.O. Box 64882
Saint Paul, MN 55101
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www.health.state.mn.us/patientsafety

As requested by Minnesota Statute 3.197: This report cost approximately $8,500 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

DEPARTMENT OF HEALTH

February 28, 2019

The Honorable Michelle Benson, Chair
Health and Human Services Finance & Policy Committee
Minnesota Senate
3109 Minnesota Senate Building
95 University Ave W.
Saint Paul, MN 55155-1606

The Honorable Rena Mora, Chair
Health and Human Services Policy Committee
Minnesota House of Representatives
575 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, MN 55155-1606

The Honorable Jim Abeler, Chair
Human Services Reform Finance & Policy Committee
Minnesota Senate
3215 Minnesota Senate Building
95 University Ave W.
Saint Paul, MN 55155-1606

The Honorable Tina Liebling, Chair
Health and Human Services Finance Committee
Minnesota House of Representatives
477 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, MN 55155-1606

Dear Honorable Chairs

As required by Minnesota Statutes, Section 144.706, this report provides an overview of events reported under Minnesota's Adverse Health Event Reporting Law during the most recent reporting year. This law requires that all hospitals and licensed surgical centers in Minnesota report to MDH any time one of 29 'events' occurs. These events include things like serious falls, wrong site surgeries and suicides.

This report provides an analysis of the data collected through the adverse health event system for the period from October 7th, 2017-October 6th, 2018. The report shows 384 adverse health events reported during this period, with 118 serious injuries and 11 deaths. This represents an increase in these events, and the highest total number since the inception of the system. The most common type of reportable events are pressure ulcers (bedsores) and falls resulting in serious injury. A highlight of this reporting year is that hospitals and surgical centers had an intense focus on preventing wrong site procedures in 2018 and reduced these events by one-third.

With the release of the 15th annual report, we believe the time is right to talk about the future of this program, which led the nation when it was passed in 2003, and about our broader work to ensure that the care delivered to MN patients is as safe as it can be. This program started in a different healthcare and political environment than we're in now. Public and private organizations collect and use more data now than 15 years ago, and through our work with hospitals and surgery centers, we know a lot more about where the greatest risks to patients are. Given that changing environment, our approach to reporting on and improving patient safety may need to evolve to match. MDH plans to convene a set of conversations in 2019, together with partners around the state, to consider how the adverse health events system is meeting the needs of patients and providers across the state and how it can be improved to further the mission of quality improvement and patient safety.

Questions or comments on the report may be directed to Rachel Jokela of the Adverse Health Events program at (651) 201-5807.

Sincerely,

Jan K. Malcolm
Commissioner
PO Box 64975
St. Paul, MN 55164-0975

CONTENTS

EXECUTIVE SUMMARY

In 2003, Minnesota became the first state in the country to pass a law requiring all hospitals and surgery centers to report whenever a serious adverse health event (Appendix A) occurs and conduct an analysis on the reasons for the occurrence. Minnesota's law remains a national gold standard in terms of transparency, and a model for other states in how to support statewide learning about adverse health events. In 2018, the total number of reported events was 384, the highest number of events in the fifteen years of reporting. As in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for 58 percent of all events reported (223 events).

This increase in total events was largely driven by a rise in pressure ulcers, retained foreign objects and the loss or damage of irreplaceable biological specimens. With respect to harm, there were 11 deaths and 118 serious injuries that resulted from the reported events.

The reporting system in Minnesota has maintained a strong focus on transparency, but also on learning. The overarching purpose of the reporting system is to use the data to identify issues or problems and learn from them so that future harm can be prevented. Ultimately, the goal is to ensure that we have the safest possible system of health care in Minnesota, and that patients are free from avoidable harm.

As a result of this learning system, a number of actions were implemented in 2018 in conjunction with community partners, including the Minnesota Hospital Association and Stratis Health:

- Development of a medical device-related pressure injury toolkit to help organizations to address issues surrounding device-related pressure injuries;
- Development of a set of new medication reconciliation best practices to assist hospitals in reducing medication errors;
- Provided training to organizations on an improved root cause analysis process, which will assist them in conducting robust root cause analyses for these events, prioritizing areas of risk, and developing effective and sustained action plans in response; and
- Provided training for organizations on suicide and self-harm prevention and ligature risk.

Throughout the lifetime of the Adverse Health Events (AHE) reporting system, the focus has been on learning and evolving the system to meet the needs of organizations and to improve patient safety in Minnesota. Because of this system, Minnesota has transformed the discussion around patient safety, by increasing transparency about serious safety events and by creating structures for hospitals and surgical centers to talk about their challenges in preventing harm and to work together to create a safer system.

Despite this strong, collaborative progress, in the last few years of reporting, the number of reported events has plateaued in several categories and increased in others. While these events might never be completely eliminated, it is clear that there is still more that we need to do to keep patients safe and to ensure that our systems for preventing events are evolving and improving, even as technology and treatments continue to evolve. In 2019, MDH is committed to convening conversations with stakeholders to look for additional ways that Minnesota can move patient safety forward to assure the absolute safest care is provided to Minnesota patients every time.

Susan's Story:

A fatal medication error leads to a daughter's lasting commitment for safer care

In 2003, I lost my mother to a preventable medical error. During a hospital admission, she received a larger-than-intended dose of intravenous medication that caused her untimely death. It happened to be the same year that the Minnesota legislature first passed the Adverse Health Events Reporting Law. The hospital was transparent with our family and did admit to their error, but the events that followed in the last eight days of her life revealed more complex layers that contributed to her tragic, preventable death.

As much as I was devastated, I was also driven to do something with the pain that I felt. I wanted to make sure that no other family experienced what mine had gone through. I was eventually connected to the Minnesota Hospital Association (MHA) and the Minnesota Alliance for Patient Safety (MAPS). I was willing to volunteer and work towards improving safety for patients and families. However, due to certain restrictions within our family's settlement with the hospital, I was not allowed to share my personal story and life-changing experience with medical error.

In spite of not sharing my personal story with the groups I worked with, I continued as a volunteer patient partner for the next 10 years. In 2015, I participated in the MAPS Patient and Family Engagement Committee where we worked towards creating a toolkit to inspire organizations to include and engage patients, residents and families at all levels in the organization, resulting in the www.includealways.com website. I also served on the MHA medication reconciliation committee in 2016 to make a contribution from a patient perspective.

But, my greatest contribution was being able to finally share my mother's story at a MHA/MAPS "Include Always" event in 2016. Thirteen years after my mother's death due to medical error, I reached out to the hospital to determine if they would give me permission to share my family's experience. I was overwhelmed when a new leader responded positively and agreed that it would be a powerful way for people to learn how to improve. To me, it was a signal the industry was changing. Her letter was kind, sincere, and created an immediate sense of healing for my heart that I otherwise wouldn't have felt. Up until that point, no one from the hospital had ever said that they were sorry to me or my family for the mistake that had occurred. I believe that the most important words that patients and families want to hear following a mistake are "We are sorry." It was a moment that didn't take my pain away, but instead brought forth a renewed sense of personal healing, as well as hope for our health systems to address errors in a way that supports families.

After I told my story at the event, the emotional reactions I received from the healthcare professionals caught me off-guard. It was healing for me to be able to finally share what had happened and to know that it would impact others in a positive way. When I was asked to write this article, I was surprised at how re-visiting the paperwork triggered so many emotions, even 15 years later. The hardest part of this journey has been the way it has affected my trust in the healthcare system. More recently, when my husband and daughter struggled through their own health crises, I realized how the error that caused my mother's death creates distrust and fear when I need to make healthcare decisions, even today. The impact of medical error might fade over time, but it never goes away.

I am so grateful for the opportunities I have been given over the years to partner with the healthcare system as they look for solutions to safety issues. It is my hope that we continue finding more opportunities to move forward by encouraging and educating a growing number of patients and families to become actively engaged with organizations to establish a positive relationship between caregivers and patients, and provide a place for patient and family voices to be heard. Together, we will go a lot further.

Submitted in partnership with the Minnesota Alliance for Patient Safety (MAPS), a 501(c) (3) nonprofit organization. MAPS works to achieve safe care everywhere by engaging a diverse stakeholder coalition that broadly represents Minnesota's health care community. MAPS is a subsidiary of Stratis Health. Together, they drive a common vision to advance safety across the care continuum, with special emphasis on elevating the voice of the patients for safety in all settings of care.

HIGHLIGHTS OF 2018 ACTIVITIES

The Minnesota Adverse Health Events Law directs the Commissioner of Health to review all reported events, root cause analyses, and corrective action plans, and provide direction to reporting facilities on how they can improve patient safety. In this work, MDH works closely with a variety of stakeholders including the Minnesota Hospital Association (MHA), and Stratis Health. Highlights of the 2018 activities include:

- MHA led the development of a medical device-related pressure injury toolkit to help organizations to address issues surrounding device-related pressure injuries;
- MDH and its partners provided training to organizations on an improved root cause analysis process, which will assist them in conducting robust root cause analyses for these events, prioritizing areas of risk, and developing effective and sustained action plans in response;
- MDH and its partners provided training for organizations on suicide and self-harm prevention, as well as ligature risks;
- MDH held two statewide webinars for reporting facilities to update them on changes to the reporting system, trends in the data, new resources/tools/projects, and upcoming training opportunities;
- MHA and a team of experts developed and disseminated new perinatal best practices in order to prevent maternal and neonatal deaths/serious injuries;
- MHA led the development of a new medication reconciliation road map (set of best practices) to assist hospitals in reducing medication errors;
- MHA provided training to organizations on early mobility in the ICU (intensive care unit) to prevent falls and delirium;
- MDH, and other Minnesota stakeholders, partnered with Minnesota Alliance for Patient Safety (MAPS) to hold its biennial education conference, a two-day education summit on patient safety and quality in the fall of 2018, with nearly 300 attendees;
- Stratis Health provided one-on-one consultation and technical assistance to reporting organizations upon request and in response to opportunities to identify common causes across events;
- MDH and its partners continued an Adverse Health Events (AHE) learning series where webinars are hosted with experts on different prevention areas, including biological specimen management and pressure ulcer prevention; and,
- In response to incidents involving health care providers and people needing medical care who are involved with law enforcement, MDH, MHA and the Minnesota Sheriff's Association co-convened a group of healthcare and law enforcement professionals to address these issues. This group met from 2016-2018 to develop a road map of best practices. In 2018, the education and dissemination of the road map occurred.

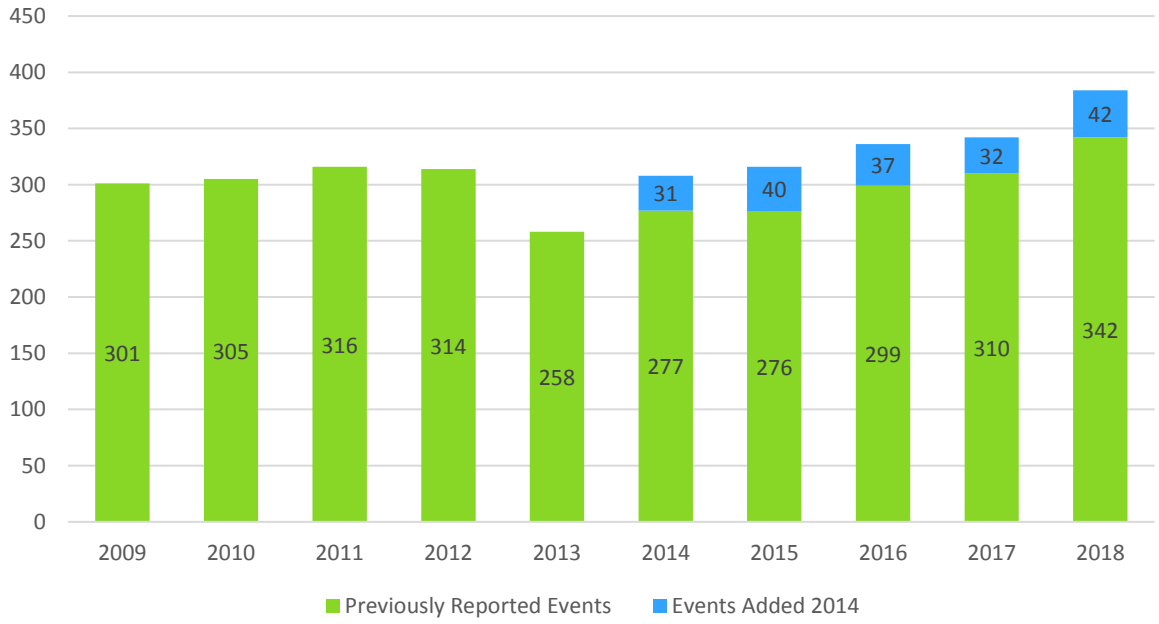
OVERVIEW OF REPORTED EVENTS & FINDINGS

In the 15 years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on nearly 4,000 events. MDH and its partners have used the findings from those events to identify ways to improve patient safety in Minnesota.

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, with a highlight on the most commonly reported events. For each of these categories of events, this report will discuss what has been learned about why these events happened and what is being done to prevent them from happening again.

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

Figure 1: **Reported Adverse Health Events 2009-2018**



FREQUENCY OF EVENTS

Between October 7, 2017, and October 6, 2018, 384 adverse health events were reported to MDH (Figure 1). Because the reporting system has changed over time, with several new event categories added to the system in 2014, numbers from 2018 are not directly comparable to the early years of the system. However, in the most recent reporting year, both newer events required to be reported and originally reported events have increased, continuing a five year trend of increases in the total number of events.

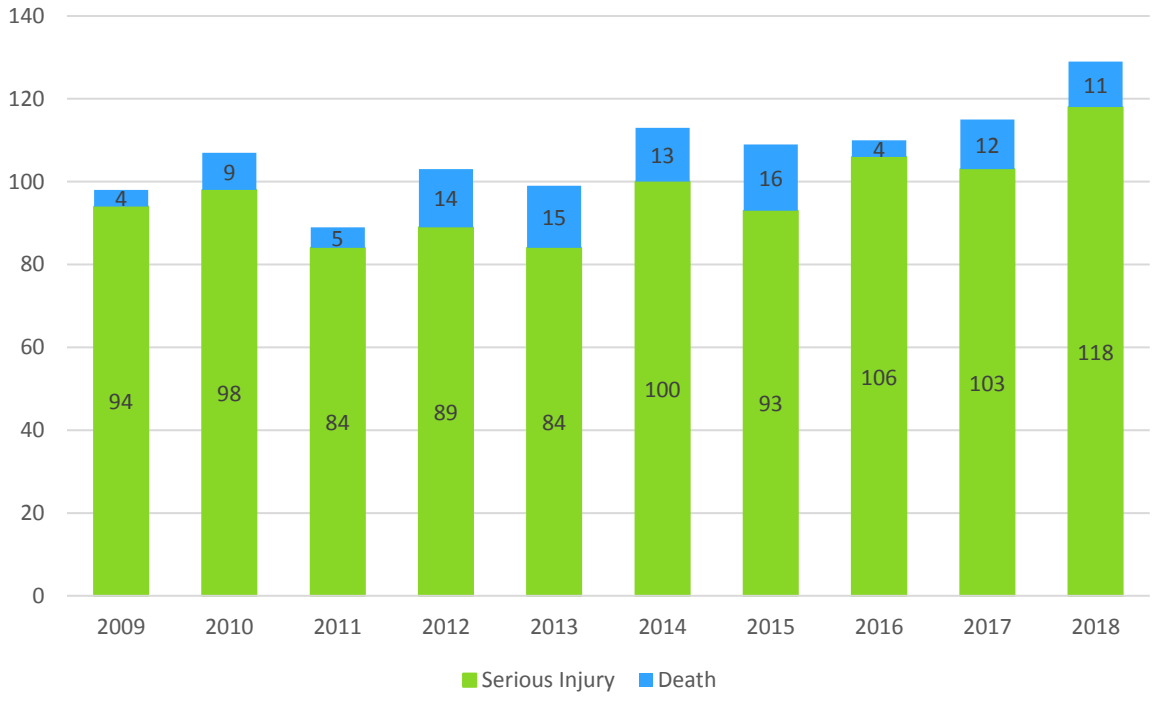
PATIENT HARM

Of the reports submitted during this reporting period, 118 events (31 percent) resulted in serious injury, while 11 events (two percent) led to the death of the patient (Figure 2). While the number of deaths is similar to most previous years, the number of serious injuries in 2018 increased.

Over the life of the reporting system, falls, medication errors and neonatal events have been the most common causes of serious patient injury or death. The pattern was similar in 2018; five of the 11 deaths were associated with falls, three with the death of a neonate, two with medication errors and one as the result of a suicide.

It is important to note that not all of the events under Minnesota's adverse health events reporting law have a threshold for the level of harm required to be reportable. Some events, such as retained foreign objects or the loss or irretrievable biological specimen, are required to be reported regardless of the level of patient harm. However, all of these events are indicators of potential system issues that could lead to harm.

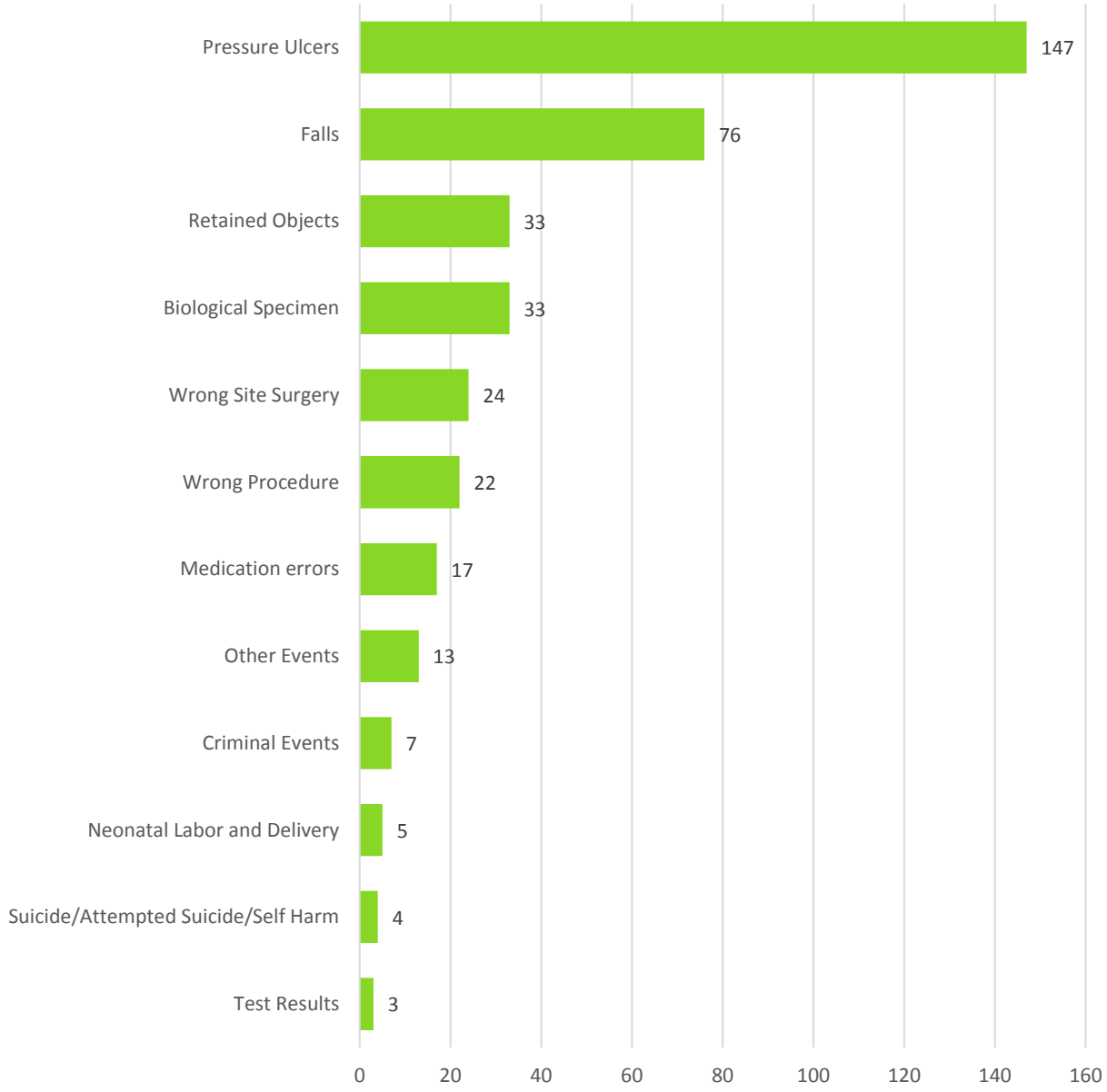
Figure 2: **Events with Harm 2009-2018**



TYPES OF EVENTS

As in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for 58 percent of all events reported (223 events). The four event types that make up the surgical/invasive procedure category accounted for another 21 percent of events this year, with 82 events (Figure 3). Appendix B provides a summary of the number of events reported in each category over the life of the system.

Figure 3: **Events by Category 2018**

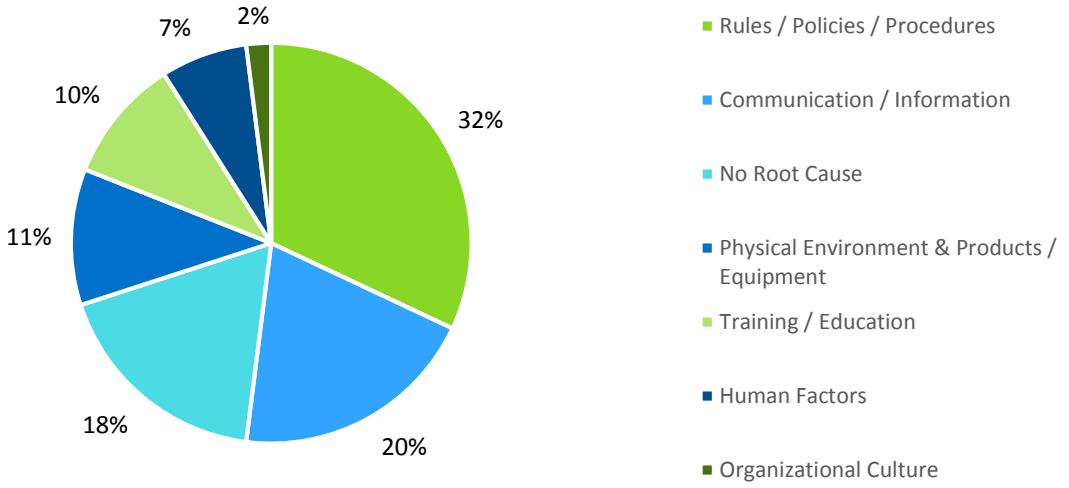


ROOT CAUSES OF ADVERSE EVENTS

When a reportable adverse event occurs, facilities are required to conduct a root cause analysis (RCA). This process involves gathering a team to closely examine the factors and circumstances that led to the event. These factors can include such things as: miscommunication, lack of compliance with or lack of clarity in policies or procedures, and problems with the underlying organizational culture. This type of analysis seeks to identify and address the root causes of events, as opposed to simply addressing their symptoms or applying a quick technical solution. By focusing corrective action on a specifically identified root cause, the recurrence of similar problems can be prevented. An ongoing challenge with RCA is that new causes of the same problem can be uncovered with each event and therefore, this process is an iterative process and should be used as a tool of continuous improvement, versus a one-time fix.

Analysis of patterns in RCA findings statewide is critical to developing and spreading best practices as a way to prevent events from happening again. In Minnesota, this process will continue to help to transform healthcare facilities to a proactive culture of identifying issues before they occur. The goal for hospitals and surgery centers is to continue to build cultures that support recognition of safety challenges and to implement solutions, rather than focusing on blame and punishment.

Figure 4: **Root Causes of Events 2018**



As in previous years, the majority of adverse events were tied to root causes in one of two areas: rules/policies/procedures and communication. This can mean that a rule or policy wasn't in place, it was in place but not followed by staff, or it wasn't an effective rule or policy. Communication issues include information not being communicated to the right person at the right time, or information not being readily available to staff.

Of note, in this reporting period, 15 percent of the time facilities were unable to identify a root cause (Figure 4). The highest number of events with no identified root cause were pressure ulcers. In these

events, the organizations usually identified that all intended preventive interventions were in place at the time of the pressure injury and a system breakdown was not found. These pressure ulcers occurred in patients that had more of the most significant, life-threatening risk factors and commonly used preventative measures such as optimal positioning, could not be implemented due to the patients' unstable condition.

After the organization identifies a root cause, they are also required to put a corrective action in place to prevent future events from happening. MDH collects data on those corrective action plans; corrective action plans are then tiered by strength and the degree to which they minimize risk of human error. Certain actions, such as training (when used alone), are considered "weak" actions. Physical plant or architectural changes are "strong" actions, because they are less prone to fail due to human error. Enhanced documentation or similar changes are considered "intermediate" actions. In this reporting period, 20 percent of reported corrective action plans were ranked as strong, 60 percent as intermediate and 20 percent as weak interventions. Over the coming year, MDH will continue to work with reporting facilities on increasing the strength of their action plans through providing technical assistance outreach to facilities.

For the last two years, reporting organizations have had the option to request one-on-one consultation or technical assistance related to the root cause analysis process, developing strong action plans, and/or approaches for monitoring improvement. Twenty seven percent of events reported this year received consultation; most commonly, this was for falls, surgical events, or biological specimen events. The consultation included exploring lessons learned across similar events, seeking to understand preceding causes to human error, sharing information on identified best practices, resources and tools, and connecting organizations with other technical experts. It also included providing assistance in identifying most effective methods to evaluate impact and success of corrective actions, and discussion or exploration of potential actions to support staff in avoiding errors, in addition to education, which on its own is a weak intervention. In the upcoming year, MDH and its partners will continue to provide assistance and support to facilities in conducting robust root cause analysis and will potentially provide additional statewide education on root cause identification, even in the most complex events.

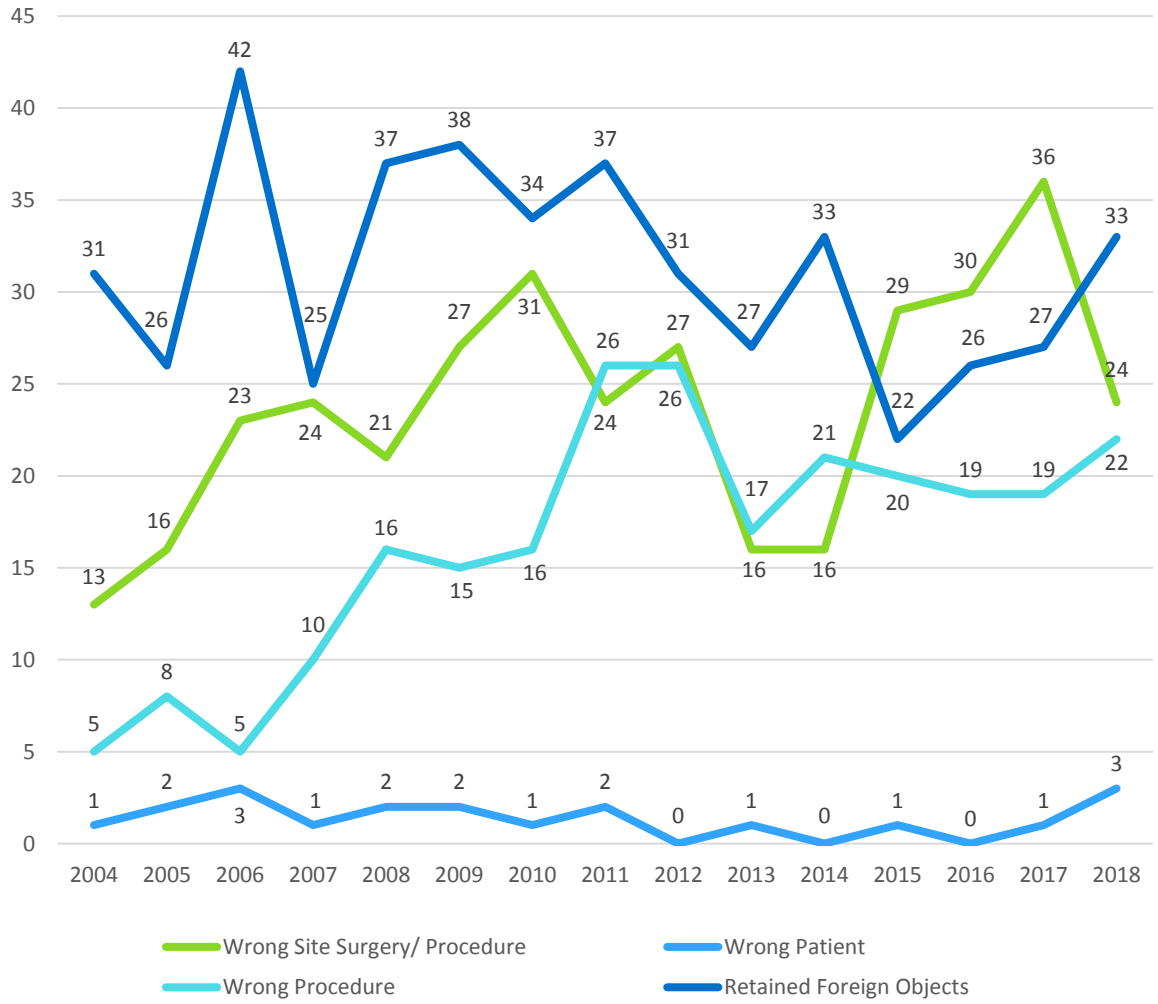
SURGICAL/INVASIVE PROCEDURE EVENTS

This section discusses detail on the most commonly reported surgical/invasive procedures events:

- Surgery or invasive procedure on the wrong part of the body (wrong site surgery/invasive procedure)
- Incidents where the wrong surgery or invasive procedure was conducted
- Foreign objects retained in a patient's body after surgery or an invasive procedure
- Surgery or invasive procedure performed on the wrong patient

In 2018, the total number of surgical/invasive procedure events across the four reporting categories was 82 (Figure 5), which is a slight increase from the prior reporting year.

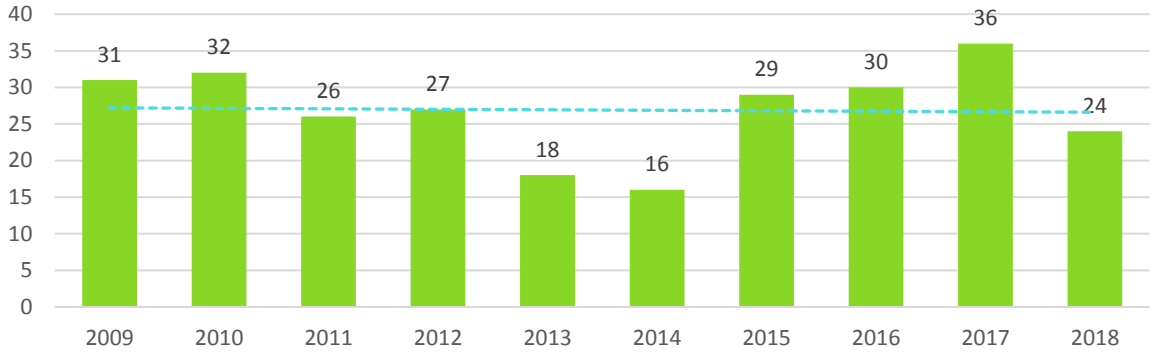
Figure 5: **Surgical/Procedural Events 2004-2018**



WRONG SITE SURGERIES/INVASIVE PROCEDURES

Twenty four cases of wrong site surgeries/invasive procedures were reported in 2018 (Figure 6). The number of reports for this category is the first decrease since 2014. While this could be an indicator that the work in the past few years to ensure the highest level of patient safety in the operating room/procedural areas is beginning to bear fruit, this event category has tended to be highly variable year to year, as of now, it's not clear if the decrease will be sustainable. It is important to note that across all Minnesota hospitals and surgical centers, over 3.2 million surgeries and invasive procedures were performed in this reporting year.

Figure 6: **Wrong Site Surgery/Invasive Procedures 2009-2018**



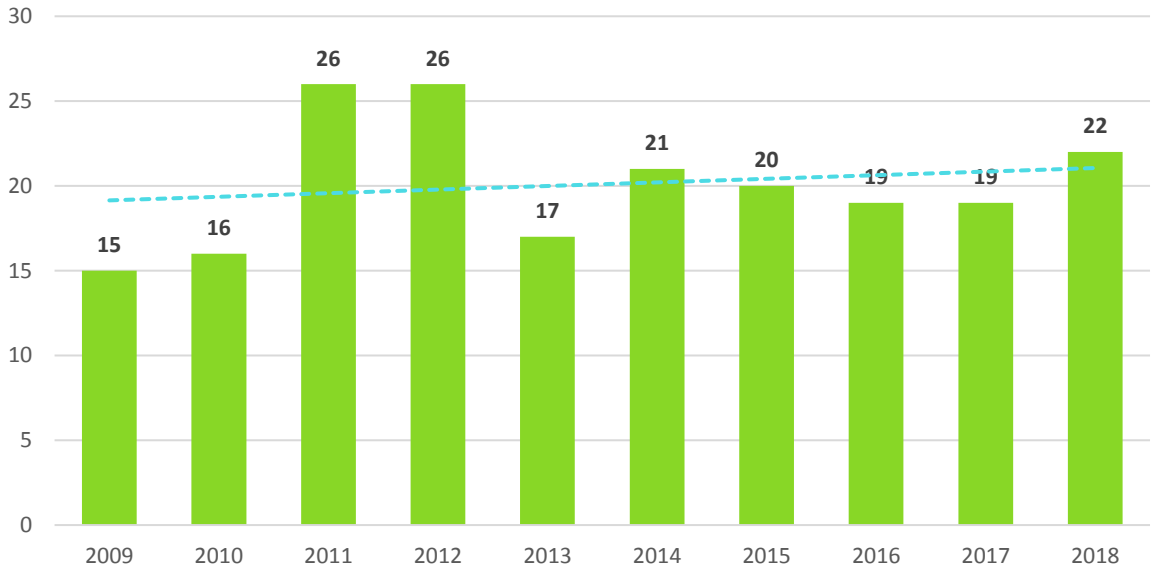
KEY FINDINGS

- The most common types of surgeries/invasive procedures involved in these events were spinal injections/procedures and other orthopedic procedures (e.g., knee replacement).
- Verification of the surgical site for spinal surgery has been a challenge to organizations for several years and continues to be. Facilities report this is due to the complex process for counting vertebrae in the spine to confirm exact location. However, as in years past, in this reporting year, nearly half of spinal wrong site events were wrong side events (e.g., right vs left side), continuing to highlight a need for improvement in the spinal surgical site location process in general.
- As in the past, the root causes of wrong site surgeries/invasive procedures are often related to inconsistencies with the Time Out process. This process is a multi-step process that must contain all of the steps in order to be effective.
  - In cases in which the surgical/invasive procedural site was required to be marked prior to the procedure, 20 percent of the time, this did not occur.
  - When the site was marked, 20 percent of the time the team did not visually confirm the site mark, which is a necessary part of the confirmation process.
  - In 12 percent of reported cases, the team did not refer to source documents to verify the procedure and/or location during the Time Out process.

WRONG SURGERIES/INVASIVE PROCEDURES

In the most recent year of reporting, hospitals and surgical centers reported 22 cases where the wrong surgery or invasive procedure was conducted on a patient (Figure 7). This number is a slight increase from the previous reporting years.

Figure 7: **Wrong Surgeries/Invasive Procedures**



KEY FINDINGS

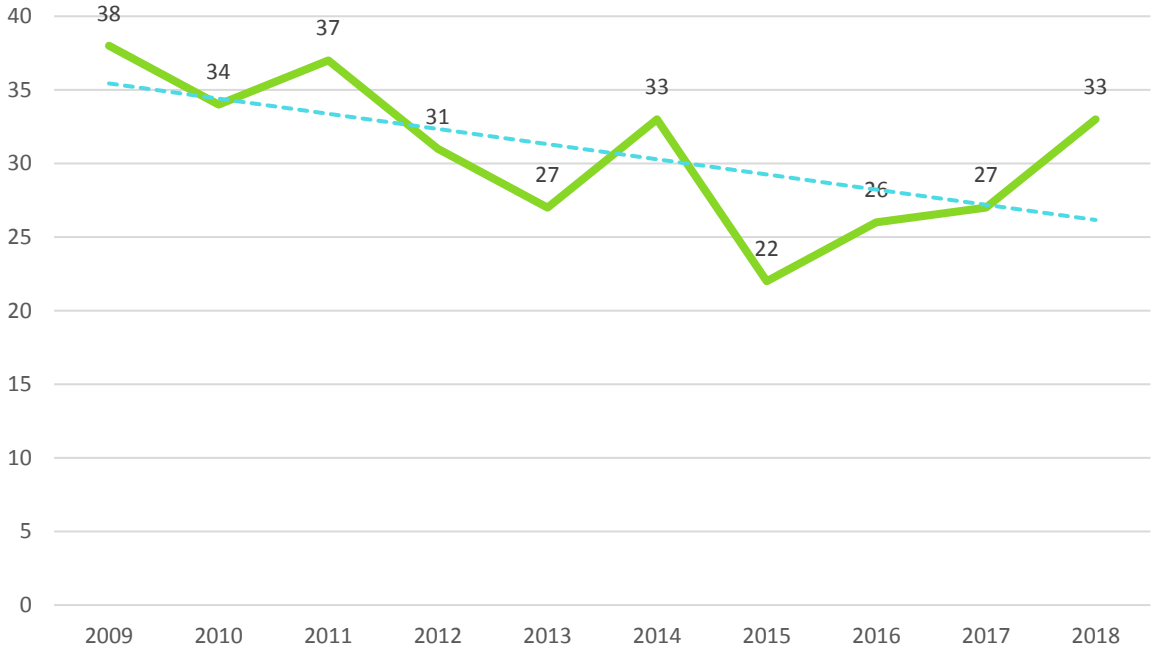
A closer look at the data shows:

- One third of wrong procedure events involved the placement of a wrong implant, similar to recent years. The most common types of implants involved in these wrong procedures were eye implants and implanted catheters.
- When a wrong surgery or invasive procedure happened, facilities reported that a Time Out was completed 100 percent of the time. However, occasional breakdowns are still occurring during the time out process itself. The most common gap in the Time Out process is that, in 13 percent of cases, the team did not cease activity during the Time Out, a critical part of the process to ensure accuracy and engagement from the team.
- Root causes for these events included consent forms that did not include the type of implant to be ordered, lack of verification of implant type prior to insertion and a scheduling process that led to confusion and resulted in the wrong procedure being ordered and scheduled.

RETAINED FOREIGN OBJECTS

In 2018, hospitals and surgical centers reported 33 cases of retained foreign objects (RFO). While the ten year trend for RFOs still shows a decrease, the number of events has increased over each of the last four years, which signals an opportunity for improvement (Figure 8).

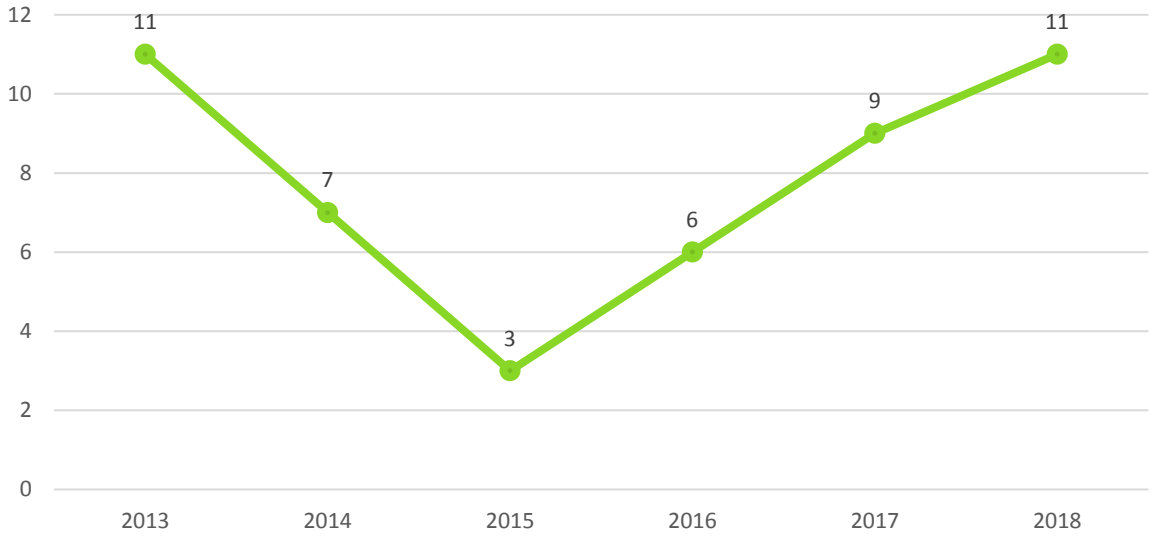
Figure 8: **Retained Foreign Objects 2009-2018**



KEY FINDINGS

- Over the past several years, there has been an increase in the retention of broken items. This year, one-third of retained objects were broken items, such as device tips and broken wires. Organizations need to remain diligent and put processes in place to account for items being intact after their use in surgery or invasive procedures.
- In past years, "packed" items (items which are intended to be removed after the procedure), have made up a significant percentage of RFOs. In the most recent reporting year, one third of events involved retained packing material (Figure 9), the third year in a row in which these events showed an increase. This increase should be a call-to-action for hospital and surgical center leadership to partner with staff to re-evaluate processes for accounting for packed items prior the patient leaving the operating room/procedural area and documenting orders to remove packed items at the prescribed time.

Figure 9: **Retained Packing Material 2013-2018**



NEXT STEPS

In the coming year, MDH and its partners will continue to provide support to facilities with training and education on best practices surrounding the Time Out process, site marking and accounting for items prior to leaving the operating room in the following ways:

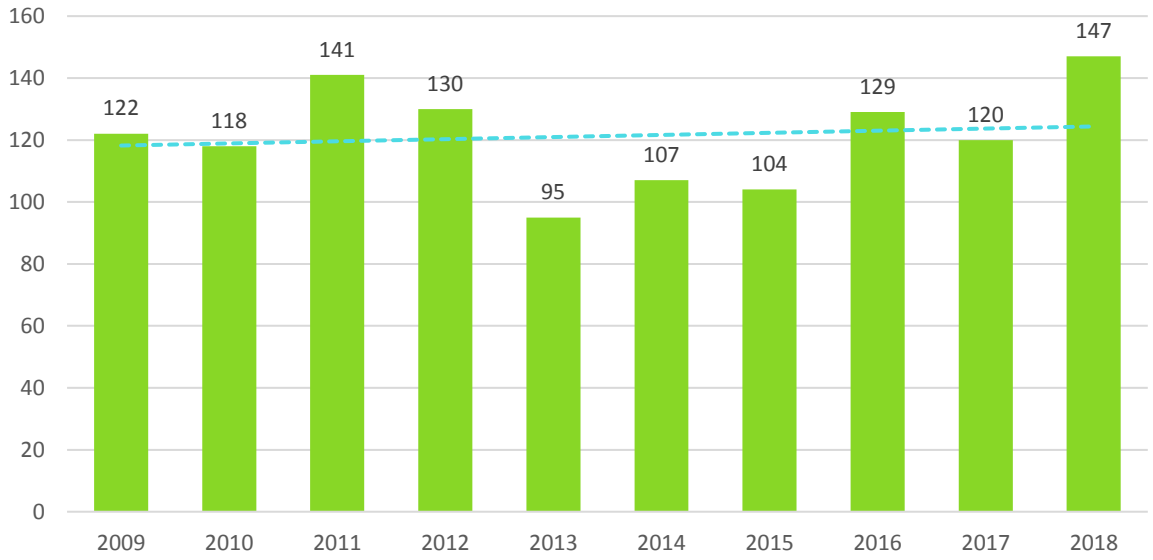
- A sub-committee worked for nearly two years to test and develop a revised Time Out process that will be disseminated statewide in the summer 2019, with accompanying education and resources for implementation;
- The MHA Surgery Committee will work to not only increase the number of hospitals and surgery centers that are implementing the surgery/procedure best practices but also actively work on those elements that have low adherence through a variety of approaches such as site visits and tailored education;
- MDH and MHA will continue to work with organizations on understanding the complexities of implant related surgical procedures and assist with implementation of site marking best practices.
- The MHA Surgery Committee has prioritized learning more about retained foreign object cases in order to identity trends and patterns. The group plans to use learnings from data analysis to develop targeted education for MN hospitals, with the goal of sharing resources and best practices.

PRESSURE ULCERS

Since the inception of the adverse health events system, pressure ulcers (also known as pressure injuries) have been the most commonly reported adverse health event, often representing roughly a third of all reported events. The number of reported pressure ulcers increased in 2018, from 120 to 147 (Figure 10); pressure ulcers have generally been on an upward trend for the past six years. Similar to last year, the majority of reported pressure ulcers were found on the coccyx, sacrum or head/neck/face.

Pressure ulcers occur when a patient's skin breaks down due to pressure or friction. While the highest risk patients are those with circulation problems, incontinence or limited mobility, a pressure injury can also form in a patient without any of these risk factors.

Figure 10: **Pressure Ulcers 2009-2018**



KEY FINDINGS

A closer look at the data shows:

- Forty-four percent of reported pressure ulcers were related to medical devices that are in contact with the patient's skin. This is similar to the past several years of data and continues to highlight an area for focused improvement for organizations. The most common devices associated with reported pressure ulcers were respiratory, urinary/fecal management systems and feeding tubes.
- In 27 percent of cases, the patient's tenuous medical condition prevented traditional repositioning methods. However, "micro shifts" can serve as an alternative to relieve pressure and assist in pressure ulcer prevention when traditional turning methods cannot be used.
- In this reporting year, 52 percent of pressure ulcers were found in the intensive care unit patients. This continues to highlight the complexity of patients and need for processes to ensure that patients are being repositioned and mobilized as often as possible.

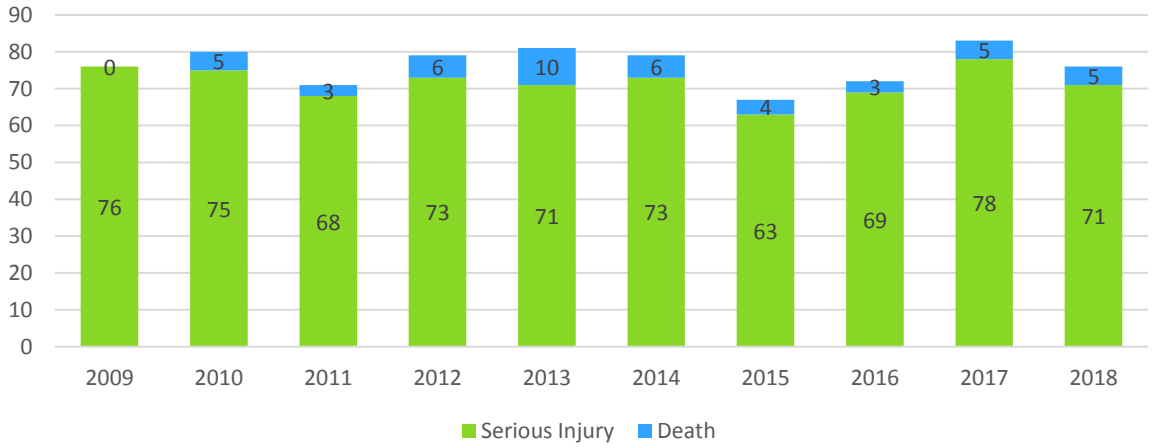
NEXT STEPS

- MHA will host a statewide Falls and Pressure Injury Prevention education conference in early 2019 in order to educate and disseminate best practices in these areas.
- MDH and its partners will disseminate easily accessible pressure injury educational modules that were developed by the pressure injury committee in 2018.
- In 2017, MHA launched a yearlong cohort program with an emphasis on technical and adaptive strategies for pressure injuries. Four hospitals statewide were led through education and learning on AHRQ's Comprehensive Unit Safety Program (CUSP). Cohort participants saw a 71 percent decrease in pressure injuries. A second yearlong cohort began in 2018 and is ongoing in 2019.

FALLS

In 2018, hospitals and surgery centers reported 71 falls that resulted in serious injury to a patient, as well as five falls that resulted in a patient death (Figure 11). The total number of falls represents a very slight decrease from the previous reporting year.

Figure 11: **Falls 2009-2018**

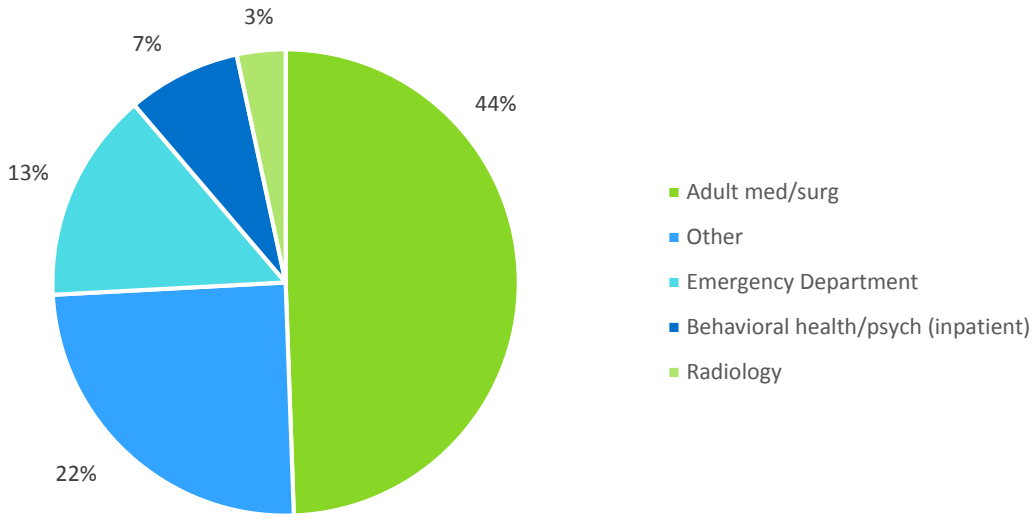


KEY FINDINGS

A closer look at the data shows that:

- Eight percent of falls occurred in the emergency department and sixteen percent occurred in the behavioral health area, highlighting the need for fall prevention improvement in these specific patient units (Figure 12).
- Similar to the past few years of data, 37 percent of falls occurred in patients who had documented behavior issues and 48 percent had cognition issues, both known risk factors for falls. Due to these unique patient populations, organizations will have to be persistent about implementing tailored fall prevention programs that address the specific needs for patients with these needs..
- In 24 percent of cases (similar to recent years), falls occurred between the patient's bed and bathroom, showing a persistent need for improvement in processes for assisting patients to the bathroom.

Figure 12: **Falls by Location 2018**



NEXT STEPS

Over the 15 years of reporting, falls have consistently been among the most commonly reported events. The fact that these numbers remain consistent and do not show any significant decrease continues to highlight the work that needs to occur in order to prevent falls and fall related injury to better protect patients. In the upcoming year:

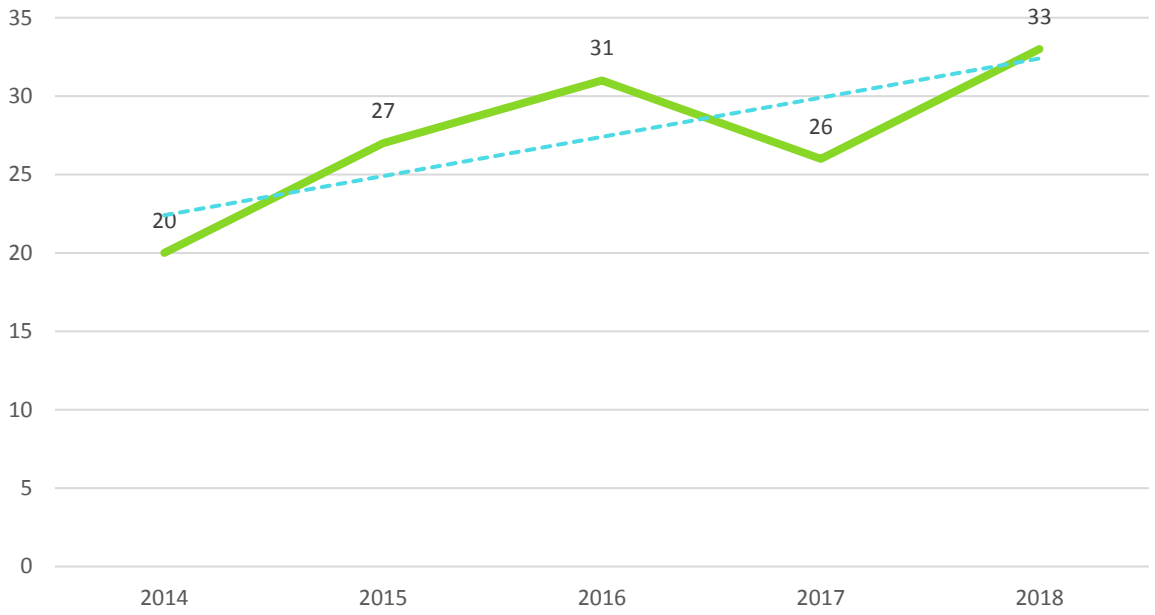
- MDH and its partners will work with reporting facilities on continued promotion and adherence to the Falls road map (a set of best practices to assist with fall prevention).
- MHA will host a statewide Falls and Pressure Ulcer Prevention education conference in early 2019 in order to educate facilities and disseminate best practices statewide in these areas.
- MHA will work to identify early mobility best practices and develop resources for hospitals to reference. Early mobility is associated with better outcomes, including avoidance of pressure ulcers, deconditioning and functional decline.
- MHA will streamline the 'Safe Patient Handling' road map in order to allow hospitals to implement best practices in a more efficient manner.
- MDH and its partners will continue to offer and provide consultation and technical assistance to organizations to aid in identification of additional fall risk factors, and promote dissemination and adoption of best practices for prevention, including targeting interventions to the patient's individualized risk factors.

IRRETRIEVABLE LOSS OF AN IRREPLACEABLE BIOLOGICAL SPECIMEN

This event category intends to protect patients from the loss of an irreplaceable biological specimen, such as a biopsy or lesion, prior to testing, which could lead to undiagnosed disease or advancing state of an existing disease. This event is intended to capture events where the specimen is mishandled (e.g., misidentified, disposed of, or lost) and another procedure cannot be done to produce a new specimen. Both criteria must be met in order to be considered a reportable event under this category.

Thirty-three of these events were reported during this fifth year of reporting (Figure 13). Of those reported events, 13 patients required additional monitoring or treatment as a result of the loss/damage to the specimen; the remaining patients did not have any physical harm from the event.

Figure 13: **Irretrievable loss of an Irreplaceable Biological Specimen 2014-2018**



KEY FINDINGS

- With regard to event location, 55 percent occurred in the operating room (this includes both inpatient and ambulatory surgery).
- The most common type of lost/damaged specimens were polyps (21 percent), biopsies (18 percent) and placentas (15 percent).
- The majority of these specimens (66 percent) were lost, 28 percent were inadvertently destroyed and six percent were damaged to the point that they could not be tested.

NEXT STEPS

MDH continues to closely monitor the increase in biological specimen cases. The MHA Surgery and Procedure Committee will identify high performers across the state and highlight their best practices as a way to increase awareness. Additionally, MHA will compare biological specimen adverse health event trends with the MHA Surgery Road Map best practice question data to identify potential improvements in recommendations.

MDH and its partners will continue to provide consultation and technical assistance upon request and in support of promotion of identified best practices.

CONCLUSION

Improving patient safety at hospitals and ambulatory surgical centers in Minnesota has proven to be a long-term, continuous process focused on learning and accountability. The reporting system has shown to be an important tool to identify key issues from reported events, leading to the development of new best practices and statewide activity to implement those practices.

This annual release of data on adverse health events is an important milestone that helps us track where we are making progress in preventing serious safety events and where we need to continue to focus efforts and resources. However, it is important to keep in mind that Minnesota facilities are working year round to identify issues and put processes in place to create safer care for their patients.

Despite the hard work and collaborative effort around patient safety in Minnesota, in the last few years of reporting the number of reported events has plateaued in some categories and increased in others. While it is true that these events might never be completely eliminated, it is clear that there is still more that we need to do to keep patients safe, and to ensure that our systems for preventing events are evolving and improving even as the population of hospitalized patients becomes more clinically complex. In 2019, MDH is committed to convening conversations with stakeholders to look for additional ways that Minnesota can move patient safety forward to assure the absolute safest care is provided to Minnesota patients every time and all instances of avoidable harm are prevented.

The following section of this report, starting on page 27, provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2017 and October 6, 2018. 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.

APPENDIX A: REPORTABLE EVENTS AS DEFINED BY LAW

Below is a list of the events that hospitals and licensed ambulatory surgical centers are required to report to the Minnesota Department of Health.

The language is taken directly from Minnesota Statutes, section 144.7065.

SURGICAL EVENTS

1. Surgery or other invasive procedure 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 or other invasive procedure performed on the wrong patient;
3. The wrong surgical or other invasive 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 invasive 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 or other invasive procedure 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 injury 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 injury 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 injury 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. A patient of any age, who does not have decision-making capacity, discharged to the wrong person;
2. Patient death or serious injury associated with patient disappearance, excluding events involving adults who have decision-making capacity; and
3. Patient suicide, attempted suicide resulting in serious injury, or self-harm resulting in serious injury or death while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

CARE MANAGEMENT EVENTS

1. Patient death or serious injury 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 injury associated with unsafe administration of blood or blood products
3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post- delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
4. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;
5. Stage 3, 4 or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;
6. Artificial insemination with the wrong donor sperm or wrong egg;
7. Patient death or serious injury associated with a fall while being cared for in a facility;
8. The irretrievable loss of an irreplaceable biological specimen; and
9. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

ENVIRONMENTAL EVENTS

1. Patient death or serious injury 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 injury associated with a burn incurred from any source while being cared for in a facility;
4. Patient death or serious injury associated with the use of or lack of restraints or bedrails while being cared for in a facility.

POTENTIAL 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 serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

RADIOLOGIC EVENTS

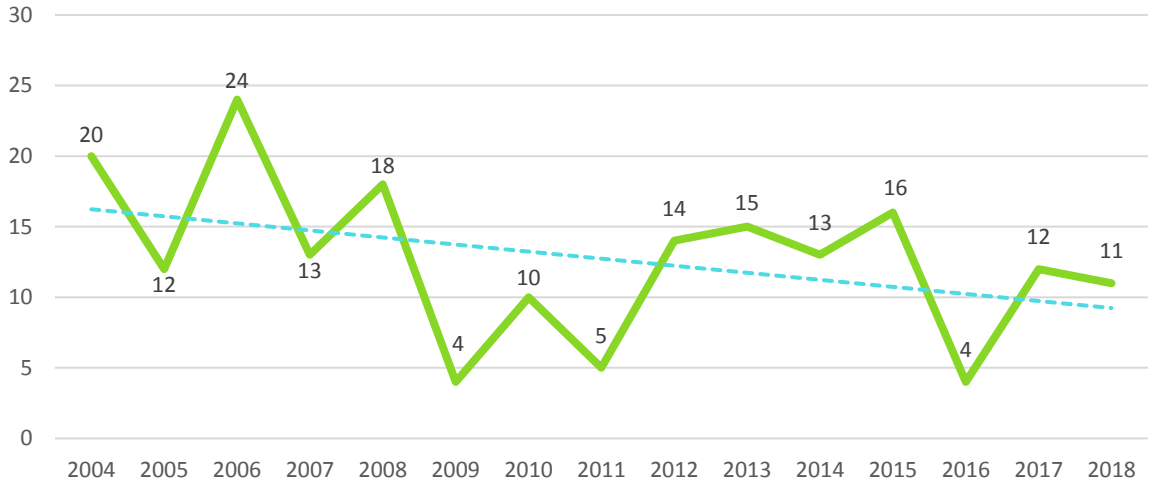
1. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

For more information about Minnesota's Adverse Health Events Reporting Law, or to view annual reports or facility-specific data, go to www.health.state.mn.us/patientsafety

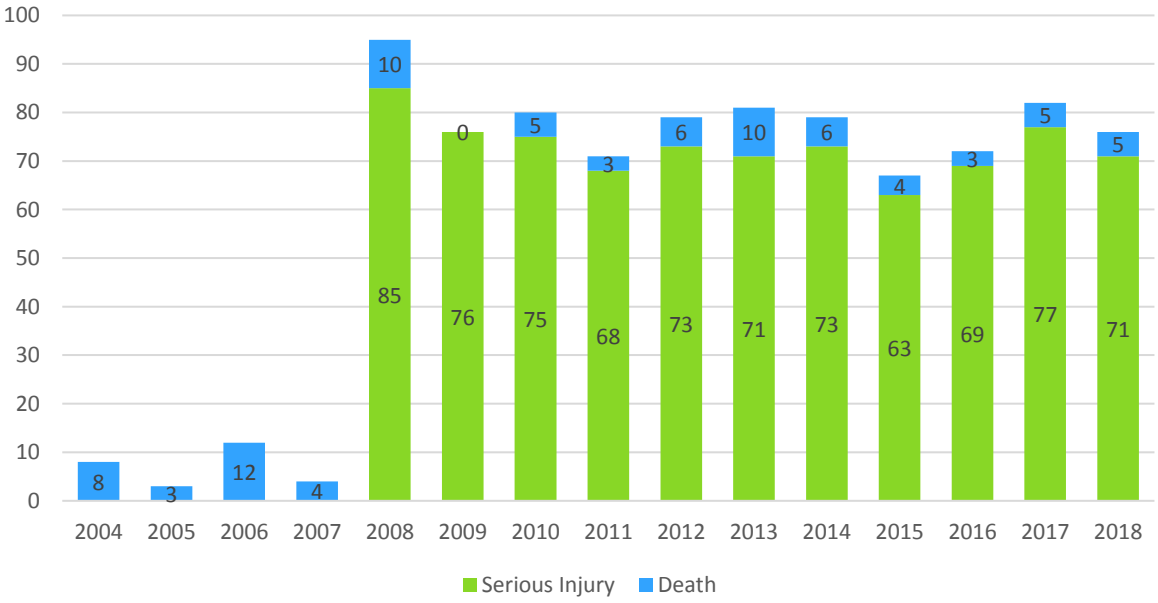
APPENDIX B: ADVERSE EVENTS DATA, 2003-2018

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.

Deaths per Year, 2004-2018

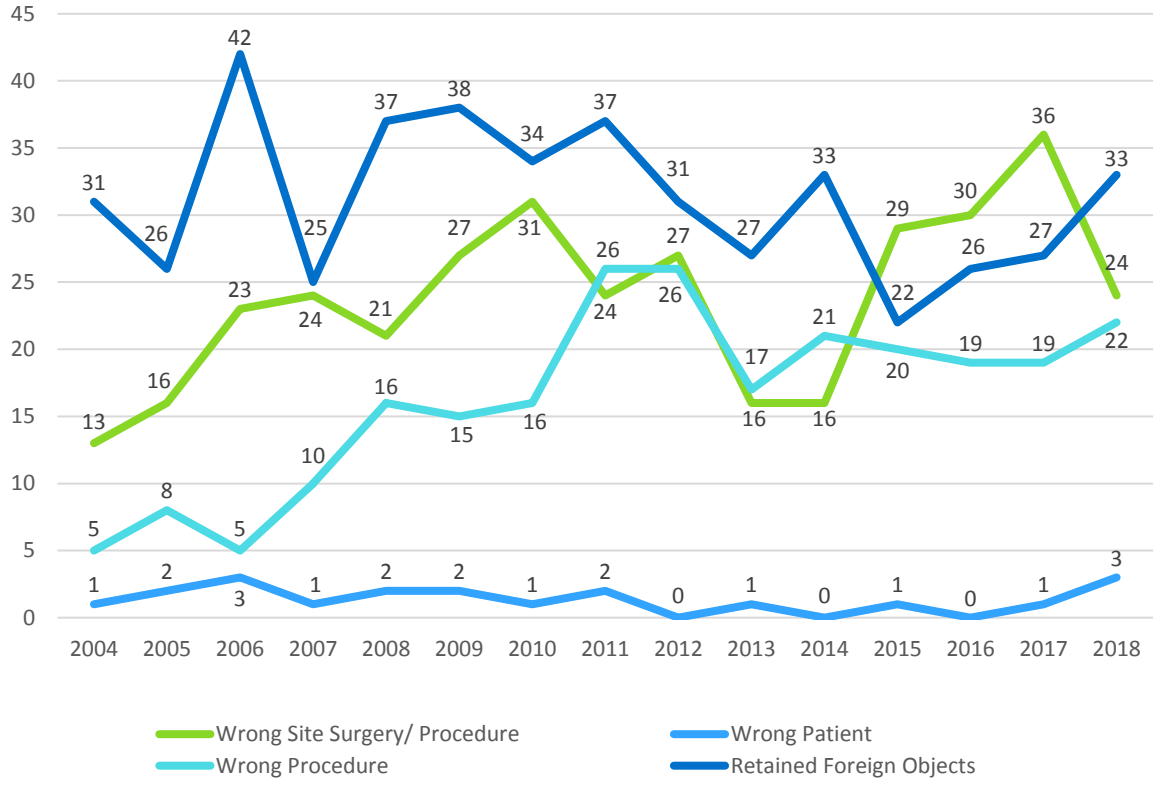


Falls per Year, 2004-2018

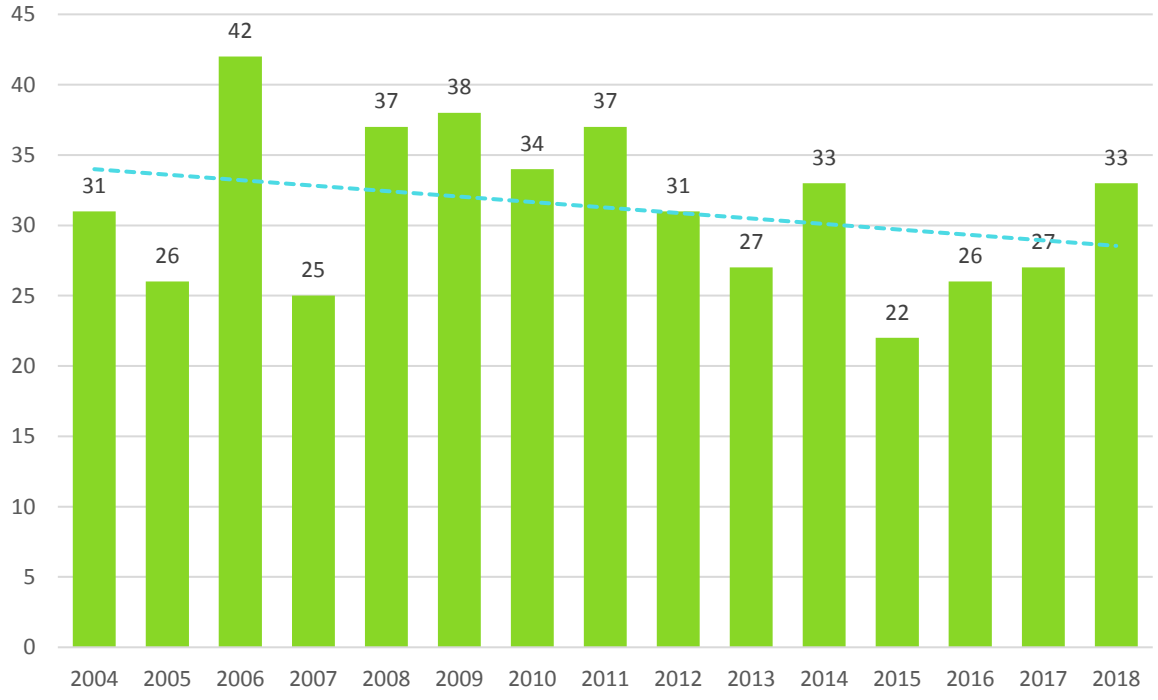


*Note, prior to 2008, facilities were only reporting falls that resulted in patient death. In 2008, the law was expanded to include falls resulting in serious injury as well.

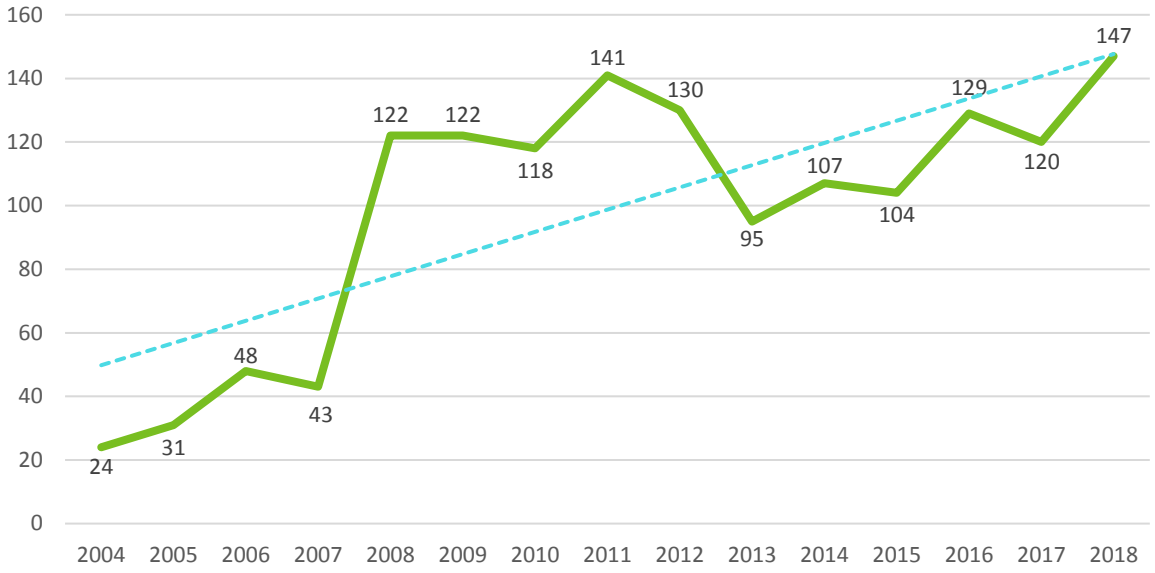
Surgical Events, 2004-2018



Retained Foreign Objects, 2004-2018



Reported Pressure Ulcers, 2004-2018



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

APPENDIX C: 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 (IOM) report "To Err is Human" in 1999. 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.

In 2012, the Adverse Health Care Events Reporting Law was modified to expand the definitions of several events, re-categorize several events, delete two events and add four additional events. Those changes went into effect with the 2014 reporting year. The four new events were:

- The irretrievable loss of an irreplaceable biological specimen;
- Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results;
- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;
- Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

At the same time the "serious disability" language was changed to "serious injury." The reporting of these new events began on Oct. 7, 2013.

OVERALL STATEWIDE REPORT

REPORTED ADVERSE HEALTH EVENTS: **ALL EVENTS**
(OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY
1. Surgical Events	82 Events	Death: 0, Serious Injury: 4, Neither: 78
2. Product or Device Events	4 Events	Death: 0, Serious Injury: 4, Neither: 0
3. Patient Protection Events	6 Events	Death: 1, Serious Injury: 4, Neither: 1
4. Care Management Events	282 Events	Death: 10, Serious Injury: 98, Neither: 174
5. Environmental Events	3 Event	Death: 0, Serious Injury: 3, Neither: 0
6. Potentially Criminal Events	7 Events	Death: 0, Serious Injury: 5, Neither: 2
Total for All Events	**384 Events**	**Death: 11, Serious Injury: 118, Neither: 255**

STATEWIDE REPORTS BY CATEGORY

DETAILS BY CATEGORY: **SURGICAL EVENTS**
(OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY
1. Wrong body part	24 Events	Death: 0, Serious Injury: 2, Neither: 22
2. Wrong Patient	3 Events	Death: 0, Serious Injury: 0, Neither: 3
3. Foreign object	33 Events	Death: 0, Serious Injury: 1, Neither: 32
4. Wrong surgical/invasive procedure performed	22 Events	Death: 0, Serious Injury:1, Neither: 21
Total Events	**82 Events**	**Death: 0, Serious Injury: 4, Neither: 78**

DETAILS BY CATEGORY: **PRODUCTS OR DEVICE EVENTS** (OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY
1. Product or device malfunction	3 Events	Death: 0, Serious Injury: 3, Neither: 0
2. Air embolism	1 Events	Death: 0, Serious Injury: 1, Neither: 0
Total Events	**4 Events**	**Death: 0, Serious Injury: 4, Neither: 0**

DETAILS BY CATEGORY: **PATIENT PROTECTION EVENTS** (OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY
1. Patient elopement	1 Event	Death: 0, Serious Injury: 1, Neither: 0
2. Patient suicide or attempted suicide resulting in serious injury	4 Events	Death: 1, Serious Injury: 3, Neither: 0
3. Discharge to wrong person	1 Event	Death: 0, Serious Injury: 0, Neither: 1
Total Events	**6 Events**	**Death: 1, Serious Injury: 4, Neither: 1**

DETAILS BY CATEGORY: **CARE MANAGEMENT EVENTS** (OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY
1. A medication error	17 Events	Death: 2, Serious Injury: 15, Neither: 0
2. Wrong blood product	1 Events	Death: 0, Serious Injury: 1, Neither: 0
3. Labor or delivery in a low-risk pregnancy (neonatal)	5 Events	Death: 3, Serious Injury: 2, Neither: 0
4. Fall while being cared for in a facility	76 Events	Death: 5, Serious Injury: 71, Neither: 0
5. Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	147 Events	Death: 0, Serious Injury: 6, Neither: 141
6. Irretrievable loss of an irreplaceable biological specimen	33 Events	Death:0, Serious Injury: 0, Neither: 33
7. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results	3 Events	Death: 0, Serious Injury: 3, Neither: 0
Total Events	**282 Events**	**Death: 10, Serious Injury: 98, Neither: 174**

DETAILS BY CATEGORY: **ENVIRONMENTAL EVENTS** (OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY
1. Death or serious injury associated with a burn	2 Events	Death: 0, Serious Injury: 2, Neither: 0
2. Death or serious injury associated with restraints	1 Event	Death: 0, Serious Injury: 1, Neither: 0
Total Events	**3 Event**	**Death: 0, Serious Injury: 3, Neither: 0**

DETAILS BY CATEGORY: **POTENTIALLY CRIMINAL EVENTS** (OCTOBER 7, 2017 – OCTOBER 6, 2018)

CATEGORY	QUANTITY	SEVERITY

1. Sexual assault on a patient	2 Events	Death: 0, Serious Injury: 0, Neither: 2
2. Death or serious injury of patient or staff from physical assault	5 Events	Death: 0, Serious Injury: 5, Neither: 0
Total Events	**7 Events**	**Death: 0, Serious Injury: 5, Neither: 2**

FACILITY-SPECIFIC DATA

ABBOTT NORTHWESTERN HOSPITAL

Minneapolis, MN

NUMBER OF BEDS:
952
NUMBER OF PATIENT DAYS:
266,001

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	17 Events	Deaths: 0, Serious Injury: 0, Neither: 17,
A Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
Medication error	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Potential Criminal Events

CATEGORY	QTY	SEVERITY
Sexual assault on a patient	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 23 | Deaths: 0, Serious Injury: 3, Neither: 20

ALOMERE HEALTH

Alexandria, MN

NUMBER OF BEDS:
127
NUMBER OF PATIENT DAYS:
36,135

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Patient Protection Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

ANOKA METRO REGIONAL TREATMENT CENTER

Anoka, MN

NUMBER OF BEDS:
175
NUMBER OF PATIENT DAYS:
34,422

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Patient Protection Events

CATEGORY	QTY	SEVERITY
Patient suicide or attempted suicide resulting in serious injury	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

ASSOCIATED EYE CARE, LLC

Stillwater, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

AVERA MARSHALL REGIONAL MEDICAL CENTER

Marshall, MN

NUMBER OF BEDS:
49
NUMBER OF PATIENT DAYS:
19,121

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 1, Neither: 1

BETHESDA HOSPITAL

Saint Paul, MN

NUMBER OF BEDS:
254
NUMBER OF PATIENT DAYS:
29,337

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 0, Neither: 2

BRAINERD LAKES SURGERY CENTER

Baxter, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

BUFFALO HOSPITAL

Buffalo, MN

NUMBER OF BEDS:
65
NUMBER OF PATIENT DAYS:
20,795

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

CARRIS HEALTH - REDWOOD

Redwood Falls, MN

NUMBER OF BEDS:
25
NUMBER OF PATIENT DAYS:
5,053

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Environmental Event

CATEGORY	QTY	SEVERITY
A burn received while being care for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

CARRIS HEALTH – RICE MEMORIAL

Willmar, MN

NUMBER OF BEDS:
136
NUMBER OF PATIENT DAYS:
24,966

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Death or serious injury of a neonate associated with labor or delivery in a low-risk	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 1, Serious Injury: 0, Neither: 0

CENTRACARE HEALTH

Monticello, MN

NUMBER OF BEDS:
39
NUMBER OF PATIENT DAYS:
10,157

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A medication error	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1 Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 2, Neither: 0

CENTRACARE HEALTH

Sauk Centre, MN

NUMBER OF BEDS:
28
NUMBER OF PATIENT DAYS:
6,603

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management

CATEGORY	QTY	SEVERITY
A medication error	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 3 | Deaths: 1, Serious Injury: 0, Neither: 2

CENTRACARE HEALTH

Long Prairie, MN

NUMBER OF BEDS:
34
NUMBER OF PATIENT DAYS:
6,141

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

CENTRACARE HEALTH

Melrose, MN

NUMBER OF BEDS:
28
NUMBER OF PATIENT DAYS:
4,796

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
A fall while being cared for in a facility	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 1, Serious Injury: 0, Neither: 1

CENTRACARE SURGERY CENTER

Saint Cloud, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

CHI SAINT JOSEPH'S HEALTH

Park Rapids, MN

NUMBER OF BEDS:
50
NUMBER OF PATIENT DAYS:
12,228

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 1, Serious Injury: 0, Neither: 0

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA

Minneapolis, MN

NUMBER OF BEDS:
279
NUMBER OF PATIENT DAYS:
148,187

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	15 Events	Deaths: 0, Serious Injury: 0, Neither: 15

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 17 | Deaths: 0, Serious Injury: 0, Neither: 17

CHIPPEWA COUNTY HOSPITAL

Montevideo, MN

NUMBER OF BEDS:
30
NUMBER OF PATIENT DAYS:
9,341

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Patient death or serious injury resulting from the failure to follow up or communicate	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

CUYUNA REGIONAL MEDICAL CENTER

Crosby, MN

NUMBER OF BEDS:
42
NUMBER OF PATIENT DAYS:
16,306

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

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

DULUTH SURGICAL SUITES LLC

Duluth, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

EAGAN SURGERY CENTER

Eagan, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

ESSENTIA HEALTH

Duluth, MN

NUMBER OF BEDS:
165
NUMBER OF PATIENT DAYS:
76,156

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 2, Neither: 0

ESSENTIA HEALTH SAINT MARY'S MEDICAL CENTER

Duluth, MN

NUMBER OF BEDS:
380
NUMBER OF PATIENT DAYS:
120,085

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
Irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 5 | Deaths: 0, Serious Injury: 3, Neither: 2

ESSENTIA HEALTH SAINT MARY'S

Detroit Lakes, MN

NUMBER OF BEDS:
87
NUMBER OF PATIENT DAYS:
22,692

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

ESSENTIA HEALTH, SAINT JOSEPH'S MEDICAL CENTER

Brainerd, MN

NUMBER OF BEDS:
162
NUMBER OF PATIENT DAYS:
62,334

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

ESSENTIA HEALTH, VIRGINIA

Virginia, MN

NUMBER OF BEDS:
83
NUMBER OF PATIENT DAYS:
20,102

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

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Irretrievable loss of an irreplaceable biological specimen	2 Event	Deaths: 0, Serious Injury: 0, Neither: 2

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 3 | Deaths: 0 Serious Injury: 0, Neither: 3

ESSENTIA HEALTH

Deer River, MN

NUMBER OF BEDS:
20
NUMBER OF PATIENT DAYS:
7,310

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 1 Serious Injury: 0, Neither: 0

FAIRVIEW LAKES MEDICAL CENTER

Wyoming, MN

NUMBER OF BEDS:
61
NUMBER OF PATIENT DAYS:
26,670

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury:2, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Potential Criminal Events

CATEGORY	QTY	SEVERITY
Death or serious injury of patient or staff from physical assault	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 5 | Deaths: 0, Serious Injury: 3, Neither: 2

FAIRVIEW NORTHLAND MEDICAL CENTER

Princeton, MN

NUMBER OF BEDS:
54
NUMBER OF PATIENT DAYS:
19,174

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

FAIRVIEW RANGE MEDICAL CENTER

Hibbing, MN

NUMBER OF BEDS:
175
NUMBER OF PATIENT DAYS:
39,836

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0

Patient Protection Events

CATEGORY	QTY	SEVERITY
A patient of any age, who does not have decision-making capacity, discharged to the wrong person.	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 3 | Deaths: 1, Serious Injury: 0, Neither: 2

FAIRVIEW RIDGES HOSPITAL

Burnsville, MN

NUMBER OF BEDS:
150
NUMBER OF PATIENT DAYS:
74,824

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Labor or delivery in a low-risk pregnancy (neonatal)	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 5 | Deaths: 0, Serious Injury: 2, Neither: 3

FAIRVIEW SOUTHDALE HOSPITAL

Edina, MN

NUMBER OF BEDS:
390
NUMBER OF PATIENT DAYS:
120,539

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

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Death or serious injury due to medication error	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	5 Events	Deaths: 0, Serious Injury: 0, Neither: 5
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0

Potential Criminal Events

CATEGORY	QTY	SEVERITY
Death or serious injury of patient or staff from physical assault	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 9 | Deaths: 0, Serious Injury: 4, Neither: 5

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

Saint Paul, MN

NUMBER OF BEDS:
60
NUMBER OF PATIENT DAYS:
23,445

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

GLENCOE REGIONAL HEALTH SERVICES

Glencoe, MN

NUMBER OF BEDS:
49
NUMBER OF PATIENT DAYS:
7,149

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

HENNEPIN HEALTHCARE

Minneapolis, MN

NUMBER OF BEDS:
894
NUMBER OF PATIENT DAYS:
226,283

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	25 Events	Deaths: 0, Serious Injury: 0, Neither: 25
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong patient	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 31 | Deaths: 0, Serious Injury: 2, Neither: 29

HUTCHINSON HEALTH

Hutchinson, MN

NUMBER OF BEDS:
66
NUMBER OF PATIENT DAYS:
27,517

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong patient	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

LAKE REGION HEALTHCARE

Fergus Falls, MN

NUMBER OF BEDS:
108
NUMBER OF PATIENT DAYS:
39,464

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

LAKEWALK SURGERY CENTER INC

Duluth, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

LAKEWOOD HEALTH SYSTEM

Staples, MN

NUMBER OF BEDS:
37
NUMBER OF PATIENT DAYS:
24,974

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
A fall while being cared for in a facility	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 3 | Deaths: 1, Serious Injury: 0, Neither: 1

MAPLE GROVE HOSPITAL

Maple Grove, MN

NUMBER OF BEDS:
130
NUMBER OF PATIENT DAYS:
40,857

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Event

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 1, Neither: 1

MAYO CLINIC HEALTH SYSTEM-ALBERT LEA & AUSTIN (AUSTIN CAMPUS)

Austin, MN

NUMBER OF BEDS: 159

NUMBER OF PATIENT DAYS: 76,526

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

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 2, Neither: 0

MAYO CLINIC HEALTH SYSTEM, FAIRMONT

Fairmont, MN

NUMBER OF BEDS:
57
NUMBER OF PATIENT DAYS:
25,834

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

MAYO CLINIC HEALTH SYSTEM

Mankato, MN

NUMBER OF BEDS:
272
NUMBER OF PATIENT DAYS:
86,602

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2

Potential Criminal Events

CATEGORY	QTY	SEVERITY
Sexual assault on a patient	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2
Surgery/Other invasive procedure performed on wrong patient	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 9 | Deaths: 0, Serious Injury: 2, Neither: 7

MAYO CLINIC HEALTH SYSTEM, RED WING

Red Wing, MN

NUMBER OF BEDS:
50
NUMBER OF PATIENT DAYS:
20,290

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 3 | Deaths: 0, Serious Injury: 0, Neither: 3

MAYO CLINIC HEALTH SYSTEM

Waseca, MN

NUMBER OF BEDS:
35
NUMBER OF PATIENT DAYS:
3,916

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

MAYO CLINIC HOSPITAL

Rochester, MN

NUMBER OF BEDS:
2,059
NUMBER OF PATIENT DAYS:
569,125

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	6 Events	Deaths: 1, Serious Injury: 5, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	11 Event	Deaths: 0, Serious Injury: 0, Neither: 11
The irretrievable loss of an irreplaceable biological specimen	4 Events	Deaths: 0, Serious Injury: 0, Neither: 4
Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	6 Events	Deaths: 0, Serious Injury: 1, Neither: 5
Wrong surgical/invasive procedure performed	10 Events	Deaths: 0, Serious Injury: 0, Neither: 10
Retention of a foreign object in a patient after surgery or other procedure	3 Event	Deaths: 0, Serious Injury: 0, Neither: 3

TOTAL EVENTS FOR THIS FACILITY: 41 | Deaths: 1, Serious Injury: 7, Neither: 33

MEEKER MEMORIAL HOSPITAL

Litchfield MN

NUMBER OF BEDS:
35
NUMBER OF PATIENT DAYS:
15,849

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 1, Neither: 1

MERCY HOSPITAL, COON RAPIDS

Coon Rapids, MN

NUMBER OF BEDS:
546
NUMBER OF PATIENT DAYS:
197,102

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

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2
Fall while being cared for in a facility	4 Events	Deaths: 0, Serious Injury: 4, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Product or Device Events

CATEGORY	QTY	SEVERITY
An intravascular air embolism	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 9 | Deaths: 0, Serious Injury: 5, Neither: 4

MERCY HOSPITAL UNITY CAMPUS, FRIDLEY

Fridley, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	4 Events	Deaths: 0, Serious Injury: 4, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 4 | Deaths: 0, Serious Injury: 4, Neither: 0

MERCY HOSPITAL

Moose Lake, MN

NUMBER OF BEDS:
25
NUMBER OF PATIENT DAYS:
7,196

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 2, Neither: 0

MILLE LACS HEALTH SYSTEM

Onamia, MN

NUMBER OF BEDS:
28
NUMBER OF PATIENT DAYS:
22,158

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	2 Events	Deaths: 1, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 1, Serious Injury: 1, Neither: 0

MINNETONKA AMBULATORY SURGERY CENTER

Minnetonka, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

NORTH MEMORIAL HEALTH AMBULATORY SURGICAL CENTER

Maple Grove, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

NORTH MEMORIAL HEALTH HOSPITAL

Robbinsdale, MN

NUMBER OF BEDS:
518
NUMBER OF PATIENT DAYS:
158,189

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	11 Events	Deaths: 0, Serious Injury: 1, Neither: 10
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2

TOTAL EVENTS FOR THIS FACILITY: 17 | Deaths: 0, Serious Injury: 3, Neither: 14

OLMSTED MEDICAL CENTER

Rochester, MN

NUMBER OF BEDS:
61
NUMBER OF PATIENT DAYS:
33,748

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

OWATONNA HOSPITAL

Owatonna, MN

NUMBER OF BEDS:
43
NUMBER OF PATIENT DAYS:
23,125

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

PARK NICOLLET METHODIST HOSPITAL

Saint Louis Park, MN

NUMBER OF BEDS:
426
NUMBER OF PATIENT DAYS:
170,031

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
Irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	3 Events	Deaths: 0, Serious Injury: 0, Neither: 3

TOTAL EVENTS FOR THIS FACILITY: 9 | Deaths: 0, Serious Injury: 3, Neither: 6

PHILLIPS EYE INSTITUTE

Minneapolis, MN

NUMBER OF BEDS:
20
NUMBER OF PATIENT DAYS:
11,309

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

REGIONS HOSPITAL

Saint Paul, MN

NUMBER OF BEDS:
454
NUMBER OF PATIENT DAYS:
237,544

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	5 Events	Deaths: 0, Serious Injury: 0, Neither: 5
Fall while being cared for in a facility	5 Events	Deaths: 0, Serious Injury: 5, Neither: 0
A reaction due to incompatible blood or blood products	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	3 Events	Deaths: 0, Serious Injury: 0, Neither: 3
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Environmental Events

CATEGORY	QTY	SEVERITY
Use of or lack of restraints or bedrails while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Product or Device Events

CATEGORY	QTY	SEVERITY
The use or malfunction of a device in patient care	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 18 | Deaths: 0, Serious Injury: 8, Neither: 10

RIDGEVIEW MEDICAL CENTER

Waconia, MN

NUMBER OF BEDS:
109
NUMBER OF PATIENT DAYS:
79,155

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

RIVER'S EDGE HOSPITAL CLINIC

Saint Peter, MN

NUMBER OF BEDS:
17
NUMBER OF PATIENT DAYS:
4,276

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

RIVERVIEW HEALTH

Crookston, MN

NUMBER OF BEDS:
25
NUMBER OF PATIENT DAYS:
2,443

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

RIVERWOOD HEALTHCARE CENTER

Aitkin, MN

NUMBER OF BEDS:
25
NUMBER OF PATIENT DAYS:
13,509

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

SAINT CLOUD HOSPITAL

Saint Cloud, MN

NUMBER OF BEDS:
489
NUMBER OF PATIENT DAYS:
192,488

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	3 Events	Deaths: 0, Serious Injury: 1, Neither: 2
Fall while being cared for in a facility	4 Events	Deaths: 0, Serious Injury: 4, Neither: 0
A medication error	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Patient Protection Events

CATEGORY	QTY	SEVERITY
Patient suicide or attempted suicide resulting in serious disability	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	2 Events	Deaths: 0, Serious Injury: 1, Neither: 1

Potential Criminal Events

CATEGORY	QTY	SEVERITY
Death or significant injury of patient or staff from physical assault	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 12 | Deaths: 0, Serious Injury: 9, Neither: 3

SAINT CLOUD SURGICAL CENTER

Saint Cloud, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 0, Neither: 2

SAINT FRANCIS REGIONAL MEDICAL CENTER

Shakopee, MN

NUMBER OF BEDS:
93
NUMBER OF PATIENT DAYS:
46,011

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility.They include the reported number for each of the 29 event types, organized under six categories.Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 1, Neither: 1

SAINT JOHN'S HOSPITAL

Maplewood, MN

NUMBER OF BEDS:
184
NUMBER OF PATIENT DAYS:
77,906

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility.They include the reported number for each of the 29 event types, organized under six categories.Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
A medication error	1 Event	Deaths: 1, Serious Injury: 0, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 7 | Deaths: 1, Serious Injury: 3, Neither: 3

SAINT JOSEPH'S HOSPITAL

Saint Paul, MN

NUMBER OF BEDS:
401
NUMBER OF PATIENT DAYS:
90,752

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Patient Protection Events

CATEGORY	QTY	SEVERITY
Patient suicide or attempted suicide resulting in serious disability	2 Events	Deaths: 1, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 4 | Deaths: 1, Serious Injury: 2, Neither: 1

SAINT LUKE'S HOSPITAL

Duluth, MN

NUMBER OF BEDS:
267
NUMBER OF PATIENT DAYS:
131,271

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
The irretrievable loss of an irreplaceable biological specimen	2 Event	Deaths: 0, Serious Injury: 1, Neither: 1
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	20 Events	Deaths: 0, Serious Injury: 0, Neither: 20
Fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 23 | Deaths: 0, Serious Injury: 2, Neither: 21

SANFORD BEHAVIORAL HEALTH CENTER

Thief River Falls, MN

NUMBER OF BEDS:
16
NUMBER OF PATIENT DAYS:
3,714

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A fall while being cared for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

SANFORD BEMIDJI MEDICAL CENTER

Bemidji, MN

NUMBER OF BEDS:
118
NUMBER OF PATIENT DAYS:
62,745

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

STEVENS COMMUNITY MEDICAL CENTER

Morris, MN

NUMBER OF BEDS:
54
NUMBER OF PATIENT DAYS:
10,570

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
A medication error	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0

TRIA ORTHOPAEDIC CENTER

Bloomington, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 2 | Deaths: 0, Serious Injury: 0, Neither: 2

UNITED HOSPITAL

Saint Paul, MN

NUMBER OF BEDS:
546
NUMBER OF PATIENT DAYS:
170,030

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Death or serious injury due to medication error	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	2 Events	Deaths: 0, Serious Injury: 0, Neither: 2
Fall while being cared for in a facility	4 Events	Deaths: 0, Serious Injury: 4, Neither: 0
Irretrievable loss of an irreplaceable biological specimen	3 Events	Deaths: 0, Serious Injury: 0, Neither: 3

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Surgery/Other invasive procedure performed on wrong body part	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Patient Protection Events

CATEGORY	QTY	SEVERITY
Patient death or serious injury associated with patient disappearance	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

Environmental Events

CATEGORY	QTY	SEVERITY
A burn received while being care for in a facility	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 16 | Deaths: 0, Serious Injury: 8, Neither: 8

UNIVERSITY OF MINNESOTA HEALTH CLINICS & SURGERY CENTER

Minneapolis, MN

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 0, Neither: 1

UNIVERSITY OF MINNESOTA MEDICAL CENTER

Minneapolis, MN

NUMBER OF BEDS:
1,700
NUMBER OF PATIENT DAYS:
358,432

HOW TO READ THESE TABLES:

These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Care Management Events

CATEGORY	QTY	SEVERITY
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious injury)	16 Events	Deaths: 0, Serious Injury: 2, Neither: 14
Fall while being cared for in a facility	6 Events	Deaths: 0, Serious Injury: 6, Neither: 0
A medication error	8 Events	Deaths: 0, Serious Injury: 8, Neither: 0
The irretrievable loss of an irreplaceable biological specimen	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1

Potential Criminal Events

CATEGORY	QTY	SEVERITY
Death or serious injury of patient or staff from physical assault	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0

Product or Device Events

CATEGORY	QTY	SEVERITY
The use or malfunction of a device in patient care	2 Events	Deaths: 0, Serious Injury: 2, Neither: 0

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Wrong surgical/invasive procedure performed	1 Event	Deaths: 0, Serious Injury: 0, Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	4 Events	Deaths: 0, Serious Injury: 0, Neither: 4

TOTAL EVENTS FOR THIS FACILITY: 40 | Deaths: 0, Serious Injury: 20, Neither: 20

WOODWINDS HEALTH CAMPUS

Woodbury, MN

NUMBER OF BEDS:
86
NUMBER OF PATIENT DAYS:
39,631

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

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2017 – OCTOBER 6, 2018)

Surgical/Other Invasive Procedure Events

CATEGORY	QTY	SEVERITY
Retention of a foreign object in a patient after surgery or other procedure	1 Event	Deaths: 0, Serious Injury: 1, Neither: 0

TOTAL EVENTS FOR THIS FACILITY: 1 | Deaths: 0, Serious Injury: 1, Neither: 0