Finding and Preventing Patient Safety Incidents

Healthgrades 2014 Patient Safety Report and Excellence Award™ Recipients

Every hospital is concerned about preventing potentially avoidable safety-related events from happening to their patients as they receive care. Despite that many protocols and approaches exist to help prevent avoidable patient safety events from occurring, there is evidence that U.S. hospitals still have room for improvement. Healthgrades found that over a three-year (2010-2012) timespan, 266,813 serious, potentially preventable patient safety events occurred among Medicare patients. To put that in perspective, that's one event for nearly every individual residing in Atlantic City, NJ.[1]

There are hospitals that have been successful in finding ways to not only reduce their safety related events, but to outperform expectations in the prevention of safety incidents. Healthgrades is pleased to recognize 381 hospitals across the nation as Healthgrades Patient Safety Excellence Award™ recipients for 2014. The distinction places this elite group of hospitals within the top 10% of all hospitals evaluated for their excellent performance in safeguarding patients from serious, potentially preventable complications during their hospital stays.

These 381 Patient Safety Excellence Award recipient hospitals showed better than expected performance in providing safety for patients in the Medicare population, as measured by objective outcomes (risk-adjusted patient safety indicator rates) across 13 of the 14 most common patient safety indicators (PSIs), as defined by the Agency for Healthcare Research and Quality (AHRQ). We applaud and honor these hospitals by recognizing them as Healthgrades 2014 Patient Safety Excellence Award™ recipients (see *Table 4*).

How Patient Safety Excellence Award Recipients Measure Up

When compared to hospitals performing worse than expected for patient safety, Healthgrades Patient Safety Excellence Award recipients had three patient safety indicators showing the largest difference in observed-to-expected ratios. On average, patients treated in Patient Safety Excellence Award hospitals were:

- 73% less likely to experience Pressure Sores or Bed Sores Acquired in the hospital compared to hospitals performing worse than expected for overall patient safety in the Medicare population.*
- 72% less likely to experience Hip Fracture following surgery compared to hospitals performing worse than expected for overall patient safety in the Medicare population.*
- 67% less likely to experience a Catheter-Related Bloodstream Infection Acquired in the Hospital compared to performing worse than expected for overall patient safety in the Medicare population.*

2014 PATIENT SAFETY STUDY HIGHLIGHTS

On average, patients treated at a Patient Safety Excellence Award™ hospital were:

73%
less likely to experience
Pressure Sores or Bed Sores
acquired in the hospital

72%
less likely to experience
Hip Fracture
following surgery

67%
less likely to experience a
Catheter-Related Bloodstream Infection
acquired in the hospital

compared to hospitals performing worse than expected in providing safety for patients in the Medicare population.*

*Statistics are based on Healthgrades application of QI Windows® Software (version 4.4), developed by the Agency for Healthcare Research and Quality (AHRQ), to MedPAR data for years 2010 through 2012 and represent three-year estimates for Medicare patients only.

Impact to the System

Safety Incidents Increase a Patient's Length of Stay

Patient safety incidents not only harm the patient, they affect the organization. As documented in a 2003 JAMA study, caring for patients experiencing these incidents increases their length of stay[2]. The impact beyond the patient's experience and condition includes the financial implications of increased direct costs and charges, which may not be reimbursed, further challenging a hospital's financial and resource pool.

Using a model created by Chunliu Zhan and Marlene Miller (2003)[3], it is possible to estimate the increase to a patient's length of stay. Based on this model, Healthgrades found that from 2010 through 2012, if all hospitals performed at the level of Patient Safety Excellence Award recipients, 352,754 inpatient days could have been avoided.

Not All Patient Safety Events Are Equal

Prioritizing Where to Focus

Healthgrades evaluated approximately 40 million Medicare hospitalizations from 2010 through 2012 and found 266,813 serious, potentially preventable patient safety events among Medicare patients in U.S. hospitals. *Table 1* shows the number of events, along with the rate per 1,000 for each of 14 AHRQ-defined patient safety indicators (PSIs).

Leaders searching to focus efforts to get the largest positive impact must recognize that it's not the areas with the highest occurrence of events that should be prioritized first– rather it's the areas where those occurrences exceed the expected number of events and have higher rates of occurrence.

Here's an example in the national data.

While events like "collapsed lung due to a procedure" are evaluated over a large number of patients (over 32 million), the overall occurrence is very low. The rate of this event is 0.43 per 1,000 patients or 0.043%.

Conversely, an event such as "death following a serious complication after surgery" is only evaluated over a small number of patients (less than 200,000) but the resulting rate is nearly 11% (107.99 per 1,000).

Not only is the impact to the patient more severe, the rate of this event occurring far exceeds the previous example.

By focusing on high rate events, hospitals can more accurately target patients, procedures and diagnoses that have a greater chance of experiencing a patient safety event.

Healthgrades Patient Safety Excellence Hospitals

From 2010 through 2012, if all hospitals had performed at the same level as the Patient Safety Excellence Award™ recipients Medicare patients in U.S. hospitals may have stayed as many as:

352,754

FEWER DAYS

in the hospital by avoiding potentially preventable patient safety events.*

* Statistics are based on a)the estimated attributable length-of-stay for each patient safety event as reported by Zhan and Miller, 2003[citation]; and b)Healthgrades application of QI Windows® Software (version 4.4), developed by the Agency for Healthcare Research and Quality (AHRQ), to MedPAR data for years 2010 through 2012, and represent 3-year estimates for Medicare patients only.

THREE PATIENT SAFETY EVENTS ACCOUNT FOR 79% OF AVOIDABLE INPATIENT DAYS

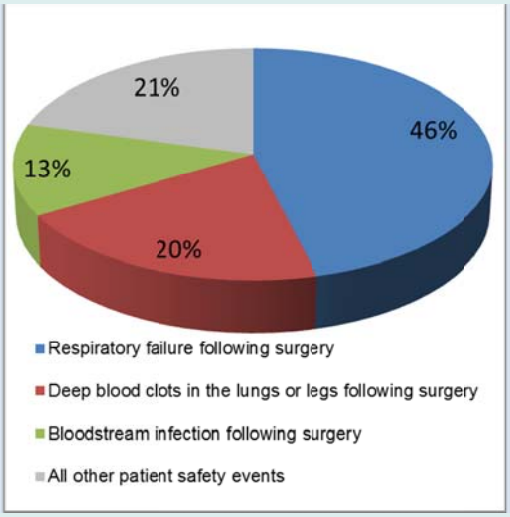

Table 1 provides a list of patient safety events prioritized by their national occurrence rate (rate per 1,000). While all patient safety events should be avoided, the Healthgrades 2014 report on patient safety has identified a set of three key avoidable patient safety events. These events have a combination of both a high rate per 1,000 and a relatively high number of events:

- Respiratory failure following surgery
- Bloodstream infection following surgery
- Deep blood clots in the lungs or legs following surgery

Before undertaking quality improvement efforts, hospitals should undergo an in-depth analysis of their unique data and patient safety performance. Hospitals can then focus on the high-incidence events first to maximize the impact of any quality improvement initiative.

Table 1. Total Number of Patient Safety Events, Cases and Rates per 1,000 for 14 PSIs (2010-2012)

Patient Safety Event	***Number of Patients Included for PSI Evaluation***	***Rate per 1,000***	***Number of Events***
Number of events of foreign objects left in body during a procedure	N/A	N/A	947
Death following a serious complication after surgery	170,419	107.99	18,403
Respiratory failure following surgery	3,761,343	17.89	67,285
Bloodstream infection following surgery	1,170,162	15.17	17,746
Deep blood clots in the lungs or legs following surgery	9,095,290	5.86	53,325
Breakdown of abdominal incision site	1,117,691	3.02	3,376
Excessive bruising or bleeding as a consequence of a procedure or surgery	9,111,522	1.82	16,566
Accidental cut, puncture, perforation or hemorrhage during medical care	34,144,165	1.76	59,945
Death in procedures where mortality is usually very low	2,022,917	1.56	3,149
Electrolyte and fluid imbalance following surgery	4,908,334	0.92	4,518
Collapsed lung due to a procedure or surgery in or around the chest	32,516,799	0.43	13,840
Catheter-related bloodstream infections acquired at the hospital	23,399,340	0.22	5,123
Pressure sores or bed sores acquired in the hospital	10,812,502	0.21	2,221
Hip fracture following surgery	5,114,655	0.07	369
Totals			***266,813***

The Case for High Reliability Principles in Healthcare

Kevin C. Webb, PhD, FACE
President, Acute Care Division, ProMedica

Achieving the Healthgrades Patient Safety Excellence Award™ in 2014 is not by accident. This achievement is a third-party validation that the actions we've taken to become a High Reliability Organization (HRO) have measurable, positive results for patients seen at ProMedica Toledo, Bixby, and Herrick Hospitals. At ProMedica we've taken the lessons learned from one facility and applied them to all of our hospitals.

For safety, our latest quest started in 2009 as we joined the Ohio Children's Hospital Association's program, Solutions for Patient Safety. Part of that program's approach uses principles found in High Reliability Organizations outside of healthcare to eliminate patient safety events. We've found this approach to be successful in addressing specific issues we've applied it to and have rolled it out to all of our hospitals.

What is a High Reliability Organization and why should we look to industries outside of healthcare for guidance? In one word: Performance.

Consider the following: In the 60 years since the launch of the first U.S. nuclear submarine, the USS Nautilus, there have been zero reactor accidents. The 6,200 reactor hours without an incident were delivered by members of a team who typically are under 25 years of age, have a high school diploma with only algebra-level math, meet the physical criteria and clear the security check. The system is built on key principles that make safety a process, rather than depend solely on an individual.

The nuclear energy industry made safety an imperative after the events of Three Mile Island in 1979. The annual industry average for significant events decreased from 0.77 to 0.09 over the fiscal years of 1988 – 2010. They reduced their safety accident rates too, from 0.38 in 1997 to 0.05 in 2012: an 86% reduction, beating their goal to get to .10 by 2015.

The common denominator for these examples is not only their results, but the methods they use and the characteristics of their operations.

Weick & Sutcliffe characterize that HROs "operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents." Traits of organizations which benefit from the principles of High Reliability include those which:

- ***Are hyper-complex***: they depend on multi-team systems that must coordinate for safety
- ***Require tight coupling***: where members depend on tasks performed across their team
- ***Exhibit extreme hierarchical differentiation***: roles are clearly differentiated and defined

If this sounds like your hospital, you might consider the concepts and practices of an HRO.

FIVE KEY CONCEPTS DISTINGUISH AN HRO

1. First, a ***preoccupation with failure*** permeates the HROs operations. They are focused not only on errors and understanding them, but also the near misses. Using both events and "almost" events as opportunities to learn and improve are an opportunity to improve.
2. Second, these organizations have ***sensitivity to operations***. They close holes in processes, pay attention to the frontline, and make it a priority that every employee feels safe to raise their hand or take action to "stop the line."
3. HROs have a ***reluctance to simplify interpretations***. Instead of grouping all things to a more generalized category, HROs ask "why" many times and work through many variations before making their conclusion.
4. The next characteristic is a ***commitment to being resilient***. HROs assume that mistakes will indeed happen. With that assumption in mind, they design their processes to detect, contain and recover from mistakes and errors.
5. Finally, HROs acknowledge that the ***person(s) closest to the frontline of the issue are the experts*** in understanding the nature of the error and the factors that contributed to the error. They empower these individuals with the authority to recommend and implement changes – deferring to their expertise.

SWISS CHEESE MODEL OF ACCIDENTS

At ProMedica, we implemented these concepts within an understanding of the "Swiss Cheese Model of Accidents." This concept, introduced by J. Reason in 2000, outlines two sources of accidents: a) ***active failures*** and b) ***latent conditions***.

Active failures are distinguished by unsafe acts committed by people: slips, lapses, fumbles, mistakes, and procedural violations and as such are difficult to foresee.

Latent conditions are driven by "resident pathogens" that are present within the system. They can come from decisions made by designers, builders, procedure writers, and management. Unlike the active failures, these sources can be identified and remedied before an adverse event occurs.

Our approach included a plan that focused on prevention, detection and correction of these accidents from their various sources. As we determined best practices to prevent errors we established a culture of safety.

After evaluating near miss trends, we were able to design detection methods and create correction actions that closed the holes in the "swiss cheese" and shared the lessons learned in a specific area with others that could use the information.

Like any model, seeing real, practical examples of it in action helps us learn and apply it to our own situation. Let me share specific actions we took at ProMedica that follow the principles of an HRO.

PREOCCUPATION WITH FAILURE

Many of the processes utilized at our hospitals, both children's hospitals as well as other short-term acute care centers, can be viewed with a perspective that could be called obsessive. From implementation of bedside reporting at shift changes to hourly rounding, our interaction with the patient and caregivers to ensure we have over communication of patient status is rooted in prevention of failure.

We implemented required check lists and progress notes for high risk procedures and as a result saw a 40% quarterly decrease in central venous line infections over four years. Strict adherence to procedural lists enabled a reduction in ventilator associated pneumonia from a high of three cases in a quarter to sustaining zero over 12 quarters.

SENSITIVITY TO OPERATIONS

Using the SEER dashboard, we have a daily safety briefing in our units and departments. We review lessons learned from ourselves and others and based on that make changes that the team believes will address the problem. In addition we implemented an online error reporting system to ensure employees had a mechanism to report safety concerns in a way that removed any threat of backlash and provided visibility to all.

We expected to see our safety event numbers to rise in the early months – a direct result of the openness and confidence employees have in the culture we've created that encourages reporting. The data validated that expectation. We've seen an overall increase in reported events since implementing the online reporting system (RL Solutions) in 2014. Rather than take that as a negative indicator, we believe this is a positive. As employees and others are empowered to report issues without threat of retribution, we can detect, correct and share the improvements with others. It's important to ensure any venture to identify and correct safety issues includes an expectation that an increase in reported events can and will occur.

RELUCTANCE TO SIMPLIFY

It's human nature to want to organize and categorize in order to make the complex simple. However, when it comes to safety, this has a detrimental effect. We employ the SEER safety event classification that encourages detail to be highlighted in understanding an event. This classification system uses the levers of patient interaction, impact, and how the event is detected to determine its severity. This allows more specific analysis and resulting action due to the detail provided.

A serious event is classified as reaching the patient, resulting in moderate to severe harm including up to death. This type of event is detected retroactively – after it occurs. The opposite scenario is described as a near miss; categorized as not having reached the patient, and therefore with no impact, and was detected as a result of a specific barrier or process in place, or in some cases by chance.

Having this model deployed at ProMedica gives us rich information on the contributing factors, allowing us to identify more methods to prevent it in the future.

COMMITMENT TO RESILIENCE

Handling unforeseen issues, recovering, and moving to prevention requires more than protocols.

At ProMedica, we use people, process and technology to provide resilience. Approaching planning with an expectation that incidents will occur, we integrate people, process and technology. Some examples include our implementation of smart pumps, CPOE, and medication

reconciliation software and hardware. These tools help us prevent events and help capture data to alert us of near misses, so we may analyze and learn from the situation, enabling a consistent quality improvement loop. This commitment is backed by the organization, our time and resources and investments.

DEFERENCE TO EXPERTISE

Finally we embarked on making it known to every employee, patient, and family member that they should expect that in their care process they would not experience more harm, they'd be healed, and in that process we would treat them with respect and kindness. According to HPI, this is the same order of importance a patient has in their expectation of care. We focused on building a culture that would deliver just that –one that reinforces appropriate behavior amongst team members and eliminates cases of nurse bullying or physician intimidation.

To ensure our frontline experts had a way to "stop the line," we determined an escalation policy that kept the employee safe to report both errors and situations that could lead to an error. Finally, we extended that concept from employees to patients, families, and visitors by deploying a campaign that communicated that they "have permission" to raise their hand, alert others, and be vocal when they experience or observe unsafe conditions.

Empowering our teams and our patients gave ultimate control to those most qualified to determine when we were not meeting the needs or goals set, and empowered them to help us solve the situation. These efforts are a journey – we know that this is hard work and will take time to eliminate safety errors in healthcare. However, we've found that by working with others, like our hospital association, and applying principles used by other industries like those used in High Reliability Organizations we can make a difference.

LESSONS LEARNED

I'll end our story with some key learnings:

1. ***Safety is a science***. Ultra- high levels of safety are indeed possible in healthcare by employing high reliability principles.
2. ***"Attention is the currency of leadership."*** The role of senior leaders in this process is absolutely critical to HRO success and where the leadership pays attention is where there will be focus in the organization.
3. ***Safety is a "dynamic, non-event."*** Everyone has a role in creating and maintaining a culture of high reliability and safety.
4. ***You must engage the medical staff*** in efforts and ensure that safety is a core value in all you do.
5. ***Everyone makes errors***, but serious patient harm events are almost always a result of the "system" failing, not an individual human's error.
6. ***Staff, physicians and leaders*** must make proven error prevention strategies a habit for their practice.

PROMEDICA
TOLEDO HOSPITAL

www.promedica.org

Kevin Webb, PhD,FACE
President, Acute Care division

For more than 25 years, Kevin Webb, PhD, FACHE, has been a medical professional and leader in healthcare. As an audiologist, Dr. Webb held management positions at both ProMedica Toledo Hospital and Lima Memorial Hospital for more than a decade. In 1991, Dr. Webb was named Vice President of Clinical Services for Lima Memorial Hospital. Over the next few years, his scope expanded to include additional management functions. This wealth of experience led him to become Corporate Director of Business Development for ProMedica Health System.

After serving as President of ProMedica Flower Hospital in Sylvania for more than eight years, Dr. Webb was named President of ProMedica Toledo Hospital in 2008. As President of ProMedica Health System's largest acute care hospital and the region's leading tertiary care facility, he provides

Strategic direction for the 774-bed hospital, which provides 30,000 admissions, 80,000 ER visits and 15,000 surgical procedures each year.

Additionally, in 2008, Dr. Webb was named President of ProMedica Toledo Children's Hospital, a 151-bed hospital dedicated exclusively to serving the healthcare needs of children and adolescents.

In 2012, he was named President, Acute Care Division of ProMedica with responsibilities for several additional hospitals including: ProMedica Bay Park, ProMedica St. Luke's, ProMedica Wildwood Orthopaedic & Spine Hospital, and ProMedica Fostoria Community Hospital

Dr. Webb is a Fellow of the American College of Healthcare Executives, Ohio Hospital Association board member, Ohio Children's Hospital Association board member, and former President of Ohio Council of Speech and Hearing Administrators. Locally, Dr. Webb is a member of the Toledo Rotary Club and is a Past President of the Sylvania Chamber of Commerce.

How Healthgrades Determines Patient Safety Excellence Award Recipients

Healthgrades Patient Safety Excellence Award™ recognizes the 381 hospitals out of 4,729 evaluated that have the lowest occurrences of 13 of 14 serious, potentially preventable complications and adverse events during a patient's hospital stay.

To evaluate hospital patient safety, Healthgrades uses Medicare inpatient data from the Medicare Provider Analysis and Review (MedPAR) database purchased from the Centers for Medicare and Medicaid Services (CMS). We evaluate all short-term acute care hospitals in the MedPAR file for three years (2010 through 2012. In addition, Healthgrades uses the QI Windows® Software (version 4.4) developed by the Agency for Healthcare Research and Quality (AHRQ).

For most patient safety indicators (PSIs), the AHRQ software uses advanced statistical algorithms that can predict the number of patient safety incidents that are likely to occur at a hospital based on the types of patients treated at that hospital. This is the expected rate.

We analyze 14 AHRQ-defined PSIs, each of which represents a serious, potentially preventable complication. *Table 3* provides AHRQ's translation for each of the 14 PSIs, as well as its description used in Healthgrades reports.*

Table 2. Patient Safety Indicators and Translation

Patient Safety Indicator	*Translated in Healthgrades Reports as…*
Death Rate Among Surgical Inpatients With Serious Treatable Complications	Death following a serious complication after surgery
Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)	Death in procedures where mortality is usually very low
Pressure Ulcer Rate	Pressure sores or bed sores acquired in the hospital
Iatrogenic Pneumothorax Rate	Collapsed lung due to a procedure or surgery in or around the chest
Central Venous Catheter-Related Bloodstream Infection Rate	Catheter-related bloodstream infections acquired at the hospital
Postoperative Hip Fracture Rate	Hip fracture following surgery
Postoperative Hemorrhage or Hematoma Rate	Excessive bruising or bleeding as a consequence of a procedure or surgery
Postoperative Physiologic and Metabolic Derangement Rate	Electrolyte and fluid imbalance following surgery
Postoperative Respiratory Failure Rate	Respiratory failure following surgery
Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate	Deep blood clots in the lungs or legs following surgery
Postoperative Sepsis Rate	Bloodstream infection following surgery
Postoperative Wound Dehiscence Rate	Breakdown of abdominal incision site
Accidental Puncture or Laceration Rate	Accidental cut, puncture, perforation or hemorrhage during medical care
Foreign Object Left During Surgery or Procedure	Foreign objects left in body during a surgery or procedure (reported as number of events)

*Healthgrades ratings reflect 14 PSIs, 13 of which are presented as rates and are used to determine Patient Safety Excellence Award recipients. One PSI, Foreign Object Left During Surgery or Procedure, is not used in award determination because it is a count as opposed to a rate.

To be eligible for the Healthgrades Patient Safety Excellence Award™, a hospital must meet clinical quality thresholds, have zero occurrences of PSI Foreign Object Left During Surgery or Procedure, and have data on at least seven out of eight core PSIs.

- ***Clinical Quality Threshold*** – Eligible hospitals must be in the top 80% of hospitals for clinical quality as ranked by average z-score across the conditions and procedures that Healthgrades evaluates using Medicare data. Hospitals that have patient safety data but no Healthgrades ratings, such as cancer centers, are also eligible.
- ***Zero Occurrences of PSI Foreign Object Left During Surgery or Procedure*** – Eligible hospitals must not have any occurrences of the PSI: Foreign Object Left During Surgery or Procedure. A hospital is ineligible for this award if even one patient has experienced this adverse event.
- ***Data for Seven of Eight Core PSIs*** – Healthgrades identifies a core set of eight PSIs that are serious, but potentially preventable, complications related to medical or surgical inpatient hospital care. This core set of PSIs is included in the CMS Inpatient Quality Reporting program and represents events that are most amenable to prevention when hospitals make changes. Eligible hospitals may have data for all 13 PSIs, but they must have data for at least seven of the eight core PSIs (see *Table 3*).

To recognize hospitals that provide excellent patient safety, Healthgrades:

1. Creates a composite patient safety z-score.
2. Calculates a significance level associated with each composite patient safety z-score.
3. Identifies those hospitals with a "Better than Expected" overall patient safety significance level (using a 90% confidence interval) as Patient Safety Excellence Award recipients.

Table 3. Healthgrades Core Set of Eight PSIs and Translation

Patient Safety Indicator	*Translated in Healthgrades Reports as…*
Pressure Ulcer Rate	Pressure sores or bed sores acquired in the hospital
Iatrogenic Pneumothorax Rate	Collapsed lung due to a procedure or surgery in or around the chest
Central Venous Catheter-Related Bloodstream Infection Rate	Catheter-related bloodstream infections acquired at the hospital
Postoperative Hip Fracture Rate	Hip fracture following surgery
Postoperative Respiratory Failure Rate	Respiratory failure following surgery
Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate	Deep blood clots in the lungs or legs following surgery
Postoperative Wound Dehiscence Rate	Breakdown of abdominal incision site
Accidental Puncture or Laceration Rate	Accidental cut, puncture, perforation or hemorrhage during medical care

For more information, please see *Healthgrades Patient Safety Ratings and Patient Safety Excellence Award™ 2014 Methodology* at **www.healthgrades.com/quality**.

About Healthgrades

Since 1998, Healthgrades has collected, reported and explained the importance of health quality outcomes to consumers. We provide consumers with critical information at the time they need it most: when selecting a physician or hospital to care for themselves or family members. In addition, by reporting quality information to the public, Healthgrades is on the forefront of driving high-quality performance by doctors and hospitals.

Over 250 million annual visitors have made the Healthgrades family of web properties the premiere destination for objective, comprehensive, consistent and credible consumer healthcare information.

Healthgrades consumer information includes:

- Risk-adjusted hospital quality outcomes based upon analysis of the Centers for Medicare and Medicaid Services (CMS) MedPAR data.
- Risk-adjusted hospital quality outcomes based upon analysis of All Payer data from hospitals representing 17 states.
- Hospital patient experience metrics based on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data.
- Hospital patient safety performance outcomes for 13 indicators of patient safety developed by the Agency for Healthcare Research and Quality.
- Information on more than 900,000 physicians in all 50 states and the District of Columbia.

Healthgrades awards hospital quality achievements for cohort-specific performance, specialty area performance, and overall best performance in these categories. For detailed performance information such as cohort-specific outcomes data and quality achievements for individual hospitals, please visit ***www.healthgrades.com/find-a-hospital***.

Healthgrades, headquartered in Denver, Colorado, is the leading online resource for comprehensive information about physicians and hospitals. More than 250 million visitors use the Healthgrades websites to search, evaluate, compare, and connect with physicians and hospitals that best meet their treatment needs. Consumers are empowered through use of the Healthgrades proprietary information about clinical outcomes, satisfaction, safety, and health conditions to make informed healthcare decisions and take action. For more information, please visit ***www.healthgrades.com*** and ***www.bettermedicine.com***.

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Healthgrades Patient Safety Excellence Award™ Recipients 2014

The following hospitals are recipients of the Healthgrades Patient Safety Excellence Award in 2014. Some of the award recipients have multiple locations. In these cases, Healthgrades analyzes the results for all locations and recognizes each of the facilities as a recipient of the award. Information on the award recipients and the rating methodology is available at *www.healthgrades.com*.

Table 4. Healthgrades Patient Safety Excellence Award Recipients 2014

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Alabama	Huntsville Hospital	Huntsville
	Including: Huntsville Hospital for Women and Children	Huntsville
	Jack Hughston Memorial Hospital	Phenix City
Arizona	Arizona Spine and Joint Hospital	Mesa
	Arrowhead Hospital	Glendale
	Banner Boswell Medical Center	Sun City
	Banner Del E. Webb Medical Center	Sun City West
	Banner Heart Hospital	Mesa
	Scottsdale Healthcare - Osborn Medical Center	Scottsdale
	Scottsdale Healthcare - Shea Medical Center	Scottsdale
	Scottsdale Healthcare - Thompson Peak Hospital	Scottsdale
	Surgical Specialty Hospital of Arizona	Phoenix
	Verde Valley Medical Center	Cottonwood
Arkansas	Arkansas Heart Hospital	Little Rock
	Arkansas Surgical Hospital	North Little Rock
	Saline Memorial Hospital	Benton
	Washington Regional Medical Center	Fayetteville
California	Alhambra Hospital Medical Center	Alhambra
	Bakersfield Heart Hospital	Bakersfield
	Bakersfield Memorial Hospital	Bakersfield
	Beverly Hospital	Montebello
	Centinela Hospital Medical Center	Inglewood
	Chino Valley Medical Center	Chino
	Desert Valley Hospital	Victorville
	Dominican Hospital	Santa Cruz
	Downey Regional Medical Center	Downey
	East Valley Hospital Medical Center	Glendora
	Enloe Medical Center	Chico

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
California (cont)	French Hospital Medical Center	San Luis Obispo
	Garden Grove Hospital and Medical Center	Garden Grove
	Glendale Memorial Hospital and Health Center	Glendale
	Good Samaritan Hospital	Los Angeles
	Hollywood Presbyterian Medical Center	Los Angeles
	Huntington Beach Hospital	Huntington Beach
	John Muir Medical Center - Concord	Concord
	John Muir Medical Center - Walnut Creek	Walnut Creek
	Kaiser Foundation Hospital - Roseville	Roseville
	Kaiser Permanente Antioch Medical Center	Antioch
	Kaiser Permanente Baldwin Park Medical Center	Baldwin Park
	Kaiser Permanente Downey Medical Center	Downey
	Kaiser Permanente Fresno Medical Center	Fresno
	Kaiser Permanente Hayward Medical Center	Hayward
	Including: Kaiser Permanente Fremont Medical Center	Fremont
	Kaiser Permanente Riverside Medical Center	Riverside
	Kaiser Permanente San Diego Medical Center - Kaiser Foundation	San Diego
	Kaiser Permanente San Jose Medical Center	San Jose
	Kaiser Permanente South Sacramento Medical Center	Sacramento
	La Palma Intercommunity Hospital	La Palma
	Los Angeles Community Hospital at Los Angeles	Los Angeles
	Including: Los Angeles Community Hospital at Norwalk	Norwalk
	Mark Twain Medical Center	San Andreas
	Memorial Hospital of Gardena	Gardena
	Oroville Hospital	Oroville
	Palm Drive Hospital	Sebastopol
	Paradise Valley Hospital	National City
	Petaluma Valley Hospital	Petaluma
	Providence Little Company of Mary Medical Center Torrance	Torrance
	Saddleback Memorial Medical Center - Laguna Hills	Laguna Hills
	Including: Saddleback Memorial Medical Center San Clemente	San Clemente
	Saint Francis Medical Center	Lynwood
	Saint John's Health Center	Santa Monica
	Saint Vincent Medical Center	Los Angeles
	San Dimas Community Hospital	San Dimas
	Santa Rosa Memorial Hospital	Santa Rosa

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
California (cont)	Sequoia Hospital	Redwood City
	Sherman Oaks Hospital	Sherman Oaks
	Sonoma Valley Hospital	Sonoma
	Sonora Regional Medical Center	Sonora
	Southwest Healthcare System - Rancho Springs Medical Center	Murrieta
	Including: Southwest Healthcare System - Inland Valley Medical Center	Wildomar
	St. Mary Medical Center	Long Beach
	St. Jude Medical Center	Fullerton
	Sutter Coast Hospital	Crescent City
	Sutter Surgical Hospital - North Valley	Yuba City
	Temple Community Hospital	Los Angeles
	Tri - City Regional Medical Center	Hawaiian Gardens
	West Anaheim Medical Center	Anaheim
	White Memorial Medical Center	Los Angeles
	Whittier Hospital Medical Center	Whittier
Colorado	Animas Surgical Hospital	Durango
	Exempla Saint Joseph Hospital	Denver
	McKee Medical Center	Loveland
	North Colorado Medical Center	Greeley
	OrthoColorado Hospital	Lakewood
	Porter Adventist Hospital	Denver
	Poudre Valley Hospital	Fort Collins
	Yampa Valley Medical Center	Steamboat Springs
Connecticut	Griffin Hospital	Derby
	Saint Francis Care	Hartford
Delaware	Saint Francis Hospital	Wilmington
District of Columbia	Sibley Memorial Hospital	Washington
Florida	Coral Gables Hospital	Coral Gables
	Fishermen's Hospital	Marathon
	Florida Hospital Orlando	Orlando
	Including: Florida Hospital - Altamonte	Altamonte Springs
	Florida Hospital - Apopka	Apopka
	Celebration Health	Celebration
	Holy Cross Hospital	Fort Lauderdale
	Leesburg Regional Medical Center	Leesburg
	Mayo Clinic	Jacksonville

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Florida (cont)	Metropolitan Hospital of Miami	Miami
	Sacred Heart Hospital On the Emerald Coast	Miramar Beach
	Saint Luke's Hospital	Jacksonville
	Saint Vincent's Medical Center	Jacksonville
	The Villages Regional Hospital	The Villages
Georgia	Emory Johns Creek Hospital	Johns Creek
	Floyd Medical Center	Rome
	Habersham County Medical Center	Demorest
	Hughston Hospital	Columbus
	Meadows Regional Medical Center	Vidalia
	Phoebe Sumter Medical Center	Americus
	St. Mary's Health Care System	Athens
	West Georgia Medical Center	Lagrange
Idaho	Northwest Specialty Hospital	Post Falls
Illinois	Advocate Good Samaritan Hospital	Downers Grove
	Advocate Lutheran General Hospital	Park Ridge
	Advocate South Suburban Hospital	Hazel Crest
	Alexian Brothers Medical Center	Elk Grove Village
	Centegra Hospital - McHenry	McHenry
	Elmhurst Memorial Hospital	Elmhurst
	Good Samaritan Regional Health Center	Mount Vernon
	Hopedale Medical Complex	Hopedale
	Mendota Community Hospital	Mendota
	Methodist Medical Center of Illinois	Peoria
	Morris Hospital and Healthcare Centers	Morris
	Presence St. Mary's Hospital	Kankakee
	Riverside Medical Center	Kankakee
	Saint Joseph's Hospital	Breese
	Swedish Covenant Hospital	Chicago
Indiana	Adams Memorial Hospital	Decatur
	Elkhart General Hospital	Elkhart
	Franciscan St. Francis Health - Mooresville	Mooresville
	Indiana Orthopaedic Hospital	Indianapolis
	Indiana University Health Ball Memorial Hospital	Muncie
	Indiana University Health Methodist Hospital	Indianapolis
	Including: Indiana University Health University Hospital	Indianapolis
	Indiana University Health North Hospital	Carmel

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Indiana (cont)	Lutheran Health Network - The Orthopedic Hospital	Fort Wayne
	Major Hospital	Shelbyville
	Parkview Hospital	Fort Wayne
	Including: Parkview North Hospital	Fort Wayne
	Parkview Ortho Hospital	Fort Wayne
	Saint Joseph Regional Medical Center	Mishawaka
	St. Vincent Carmel Hospital	Carmel
	St. Vincent Heart Center of Indiana	Indianapolis
	Unity Medical and Surgical Hospital	Mishawaka
Iowa	Allen Memorial Hospital	Waterloo
	Genesis Medical Center West - Davenport	Davenport
	Iowa Lutheran Hospital	Des Moines
	Mary Greeley Medical Center	Ames
	Mercy Medical Center - Dubuque	Dubuque
	Mercy Medical Center - North Iowa	Mason City
	Pella Regional Health Center	Pella
	Saint Anthony Regional Hospital	Carroll
Kansas	Great Bend Regional Hospital	Great Bend
	Heartland Spine and Specialty Hospital	Overland Park
	Kansas City Orthopaedic Institute	Leawood
	Kansas Heart Hospital	Wichita
	Kansas Surgery & Recovery Center	Wichita
	Newton Medical Center	Newton
	Salina Surgical Hospital	Salina
	Shawnee Mission Medical Center	Shawnee Mission
	Via Christi Hospital on Saint Francis	Wichita
Kentucky	Baptist Health Lexington	Lexington
	T.J. Samson Community Hospital	Glasgow
Louisiana	Louisiana Heart Hospital	Lacombe
	Ochsner Medical Center	New Orleans
	Including: Ochsner Medical Center- West Bank Campus	Gretna
	Ochsner Hospital - Elmwood	Harahan
	Ochsner Medical Center - Baton Rouge	Baton Rouge
	Our Lady of Lourdes Regional Medical Center	Lafayette
	P. and S. Surgical Hospital	Monroe
	Specialists Hospital Shreveport	Shreveport
	Thibodaux Regional Medical Center	Thibodaux

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Maine	Cary Medical Center	Caribou
	Mercy Hospital	Portland
	Miles Memorial Hospital	Damariscotta
Maryland	Holy Cross Hospital	Silver Spring
	MedStar St. Mary's Hospital	Leonardtown
	University of Maryland St. Joseph Medical Center	Towson
Massachusetts	Baystate Medical Center	Springfield
	Metrowest Medical Center	Framingham
	Including: Leonard Morse Hospital	Natick
	New England Baptist Hospital	Boston
	Newton - Wellesley Hospital	Newton
	Norwood Hospital	Norwood
	Saint Elizabeth's Medical Center	Brighton
	Southcoast Hospitals Group - Charlton Memorial	Fall River
	Including: Southcoast Hospitals Group - St. Luke's Hospital	New Bedford
	Southcoast Hospitals Group - Tobey Hospital	Wareham
Michigan	Allegiance Health	Jackson
	Beaumont Hospital - Troy	Troy
	Botsford Hospital	Farmington Hills
	Chelsea Community Hospital	Chelsea
	Covenant Medical Center	Saginaw
	Garden City Hospital	Garden City
	Huron Medical Center	Bad Axe
	Lakeland Hospital Saint Joseph	Saint Joseph
	Including: Lakeland Medical Center Niles	Niles
	Marquette General Hospital	Marquette
	McLaren Bay Region	Bay City
	Otsego Memorial Hospital	Gaylord
	ProMedica Bixby Hospital	Adrian
	ProMedica Herrick Hospital	Tecumseh
	Saint Mary Mercy Hospital	Livonia
	Spectrum Health Zeeland Community Hospital	Zeeland
	Spectrum Health- Butterworth Hospital	Grand Rapids
	Including: Spectum Health - Blodgett Hospital	Grand Rapids
	University of Michigan Health System	Ann Arbor

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Minnesota	Chippewa County-Montevideo Hospital and Medical Clinic	Montevideo
	Essentia Health - St. Mary's Medical Center	Duluth
	Grand Itasca Clinic and Hospital	Grand Rapids
	Healtheast Saint John's Hospital	Maplewood
	Lakeview Hospital	Stillwater
	Mercy Hospital	Coon Rapids
	New Ulm Medical Center	New Ulm
	North Memorial Medical Center	Robbinsdale
	Owatonna Hospital	Owatonna
	Rice Memorial Hospital	Willmar
	Saint Joseph's Hospital	Saint Paul
Mississippi	Forrest General Hospital	Hattiesburg
	Greenwood Leflore Hospital	Greenwood
	Hancock Medical Center	Bay Saint Louis
Missouri	Citizens Memorial Hospital	Bolivar
	Northeast Regional Medical Center	Kirksville
	Including: Grim - Smith Hospital and Clinic	Kirksville
	Ozarks Medical Center	West Plains
Montana	Billings Clinic	Billings
	Great Falls Clinic Medical Center	Great Falls
	Health Center Northwest	Kalispell
	Saint Patrick Hospital	Missoula
Nebraska	Alegent Creighton Health Immanuel Medical Center	Omaha
	Good Samaritan Hospital	Kearney
	Great Plains Regional Medical Center	North Platte
	Lincoln Surgical Hospital	Lincoln
	Midwest Surgical Hospital	Omaha
	Nebraska Heart Institute and Heart Hospital	Lincoln
	Nebraska Orthopaedic Hospital	Omaha
	Nebraska Spine Hospital	Omaha
	The Nebraska Medical Center	Omaha
New Hampshire	Franklin Regional Hospital	Franklin
	Frisbie Memorial Hospital	Rochester
New Jersey	AtlantiCare Regional Medical Center - Atlantic City	Atlantic City
	Including: AtlantiCare Regional Medical Center - Mainland	Pomona
	Bayshore Community Hospital	Holmdel

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
New Jersey (cont)	Clara Maass Medical Center	Belleville
	Englewood Hospital & Medical Center	Englewood
	Libertyhealth - Jersey City Medical Center	Jersey City
New Mexico	Rehoboth McKinley Christian Health Care Services	Gallup
	San Juan Regional Medical Center	Farmington
New York	Albany Medical Center Hospital	Albany
	Benedictine Hospital	Kingston
	Community Memorial Hospital	Hamilton
	Franklin Hospital	Valley Stream
	Hospital for Special Surgery	New York
	Huntington Hospital	Huntington
	Our Lady of Lourdes Memorial Hospital	Binghamton
	St. Luke's Cornwall Hospital	Newburgh
North Carolina	CarolinaEast Medical Center	New Bern
	Carolinas Medical Center - Northeast	Concord
	Duke Health Raleigh Hospital	Raleigh
	Frye Regional Medical Center	Hickory
	Hugh Chatham Memorial Hospital	Elkin
	Kings Mountain Hospital	Kings Mountain
	New Hanover Regional Medical Center	Wilmington
	Including: Cape Fear Hospital	Wilmington
	North Carolina Specialty Hospital	Durham
	Rex Hospital	Raleigh
	Saint Luke's Hospital	Columbus
	Stanly Regional Medical Center	Albemarle
	The Moses H. Cone Memorial Hospital	Greensboro
	Including: Wesley Long Community Hospital	Greensboro
	Annie Penn Memorial Hospital	Reidsville
	Vidant Roanoke-Chowan Hospital	Ahoskie
Ohio	Crystal Clinic Orthopaedic Center	Akron
	Dublin Methodist Hospital	Dublin
	Euclid Hospital	Euclid
	Grandview Medical Center	Dayton
	Highland District Hospital	Hillsboro
	Kettering Medical Center	Kettering
	Marion General Hospital	Marion

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Ohio (cont)	Mercy Health - Anderson Hospital	Cincinnati
	Mercy Health - Western Hills Hospital	Cincinnati
	Mount Carmel New Albany Surgical Hospital	New Albany
	O'Bleness Memorial Hospital	Athens
	Pomerene Hospital	Millersburg
	ProMedica Toledo Hospital	Toledo
	Riverside Methodist Hospital	Columbus
	Samaritan Regional Health System	Ashland
	Including: Peoples Hospital	Mansfield
	St. John Medical Center	Westlake
	Union Hospital	Dover
	University Hospitals Geauga Medical Center	Chardon
	Wayne HealthCare	Greenville
Oklahoma	McBride Orthopedic Hospital	Oklahoma City
	Medical Center of Southeastern Oklahoma	Durant
	Oklahoma Center for Orthopaedic & Multi - Specialty Surgeries	Oklahoma City
	Oklahoma Heart Hospital	Oklahoma City
	Oklahoma Heart Hospital South	Oklahoma City
	Oklahoma Surgical Hospital	Tulsa
	Saint John Broken Arrow	Broken Arrow
	Tulsa Spine and Specialty Hospital	Tulsa
Oregon	Kaiser Sunnyside Medical Center	Clackamas
	Mercy Medical Center	Roseburg
	Providence Saint Vincent Medical Center	Portland
	Saint Charles Medical Center - Redmond	Redmond
Pennsylvania	Doylestown Hospital	Doylestown
	Dubois Regional Medical Center	Du Bois
	Excela Health Frick Hospital	Mount Pleasant
	Excela Health Latrobe Hospital	Latrobe
	Geisinger - Community Medical Center	Scranton
	Mount Nittany Medical Center	State College
	OSS Orthopaedic Hospital	York
	Regional Hospital of Scranton	Scranton
	Saint Vincent Health Center	Erie
	Soldiers and Sailors Memorial Hospital	Wellsboro
	Surgical Specialty Center at Coordinated Health	Allentown

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Rhode Island	Kent Hospital	Warwick
South Carolina	AnMed Health Medical Center	Anderson
	Sisters of Charity Providence Hospitals	Columbia
	Spartanburg Regional Medical Center	Spartanburg
	Waccamaw Community Hospital	Murrells Inlet
South Dakota	Avera Heart Hospital of South Dakota	Sioux Falls
	Avera Sacred Heart Hospital	Yankton
	Avera St. Luke's Hospital	Aberdeen
	Black Hills Surgical Hospital	Rapid City
	Siouxland Surgery Center	Dakota Dunes
Tennessee	Franklin Woods Community Hospital	Johnson City
	Jackson - Madison County General Hospital	Jackson
	Saint Thomas West Hospital	Nashville
Texas	Baptist Beaumont Hospital	Beaumont
	Baylor Jack and Jane Hamilton Heart and Vascular Hospital	Dallas
	Baylor Medical Center at Uptown	Dallas
	Baylor Orthopedic and Spine Hospital at Arlington	Arlington
	Baylor Surgical Hospital at Fort Worth	Fort Worth
	CHRISTUS Spohn Hospital Alice	Alice
	CHRISTUS Spohn Hospital Kleberg	Kingsville
	East Texas Medical Center Athens	Athens
	Fort Duncan Regional Medical Center	Eagle Pass
	Good Shepherd Medical Center	Longview
	Grace Medical Center	Lubbock
	Harlingen Medical Center	Harlingen
	Hendrick Medical Center	Abilene
	Hill Country Memorial Hospital	Fredericksburg
	Houston Methodist West Hospital	Houston
	Houston Physicians' Hospital	Webster
	Kell West Regional Hospital	Wichita Falls
	Matagorda Regional Medical Center	Bay City
	Memorial Hermann Katy Hospital	Katy
	Methodist Ambulatory Surgery Hospital - Northwest	San Antonio
	Methodist Hospital for Surgery	Addison
	North Central Surgical Center	Dallas
	Northwest Hills Surgical Hospital	Austin

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Texas (cont)	Quail Creek Surgical Hospital	Amarillo
	San Angelo Community Medical Center	San Angelo
	Scott and White Hospital - Llano	Llano
	Scott and White Memorial Hospital	Temple
	Including: McLane Children's Hospital- Scott & White	Temple
	Shannon Medical Center	San Angelo
	Including: Shannon Medical Center - St. John's	San Angelo
	South Texas Spine & Surgical Hospital	San Antonio
	South Texas Surgical Hospital	Corpus Christi
	St. Anthony's Hospital	Houston
	St. David's Medical Center	Austin
	Including: Heart Hospital of Austin	Austin
	St. David's Georgetown Hospital	Georgetown
	Texas Health Harris Methodist Azle	Azle
	Texas Health Harris Methodist Hospital Hurst - Euless - Bedford	Bedford
	Texas Health Harris Methodist Hospital Southlake	Southlake
	Texas Health Presbyterian Hospital Rockwall	Rockwall
	Texas Orthopedic Hospital	Houston
	Texas Spine and Joint Hospital	Tyler
	The Hospital at Westlake Medical Center	Austin
	University General Hospital	Houston
	USMD Hospital at Arlington	Arlington
Utah	Lakeview Hospital	Bountiful
	Logan Regional Hospital	Logan
	The Orthopedic Specialty Hospital	Murray
Vermont	Central Vermont Medical Center	Berlin
	Porter Medical Center	Middlebury
	Rutland Regional Medical Center	Rutland
Virginia	Augusta Health	Fishersville
	Bon Secours - Maryview Medical Center	Portsmouth
	Carilion New River Valley Medical Center	Christiansburg
	Inova Alexandria Hospital	Alexandria
	Inova Loudoun Hospital	Leesburg
	Johnston Memorial Hospital	Abingdon
	Sentara Williamsburg Regional Medical Center	Williamsburg
	Shenandoah Memorial Hospital	Woodstock

State	Healthgrades Patient Safety Excellence Award Recipients 2014	City
Washington	Kittitas Valley Community Hospital	Ellensburg
	Providence Holy Family Hospital	Spokane
	Providence Sacred Heart Medical Center	Spokane
	Providence Saint Mary Medical Center	Walla Walla
West Virginia	Fairmont General Hospital	Fairmont
	Mon General Hospital	Morgantown
	Weirton Medical Center	Weirton
Wisconsin	Aurora BayCare Medical Center	Green Bay
	Aurora Memorial Hospital Burlington	Burlington
	Aurora Saint Luke's Medical Center	Milwaukee
	Including: Saint Luke's Medical Center	Cudahy
	Aurora Sinai Medical Center	Milwaukee
	Columbus Community Hospital	Columbus
	Mayo Clinic Health System - Northland	Barron
	Memorial Medical Center	Ashland
	Mercy Medical Center	Oshkosh
	Oakleaf Surgical Hospital	Eau Claire
	Richland Hospital	Richland Center
	Saint Mary's Hospital	Madison
	Saint Vincent Hospital	Green Bay
	Sauk Prairie Memorial Hospital	Prairie Du Sac