



Adverse Health Events Chartbook

July 2026

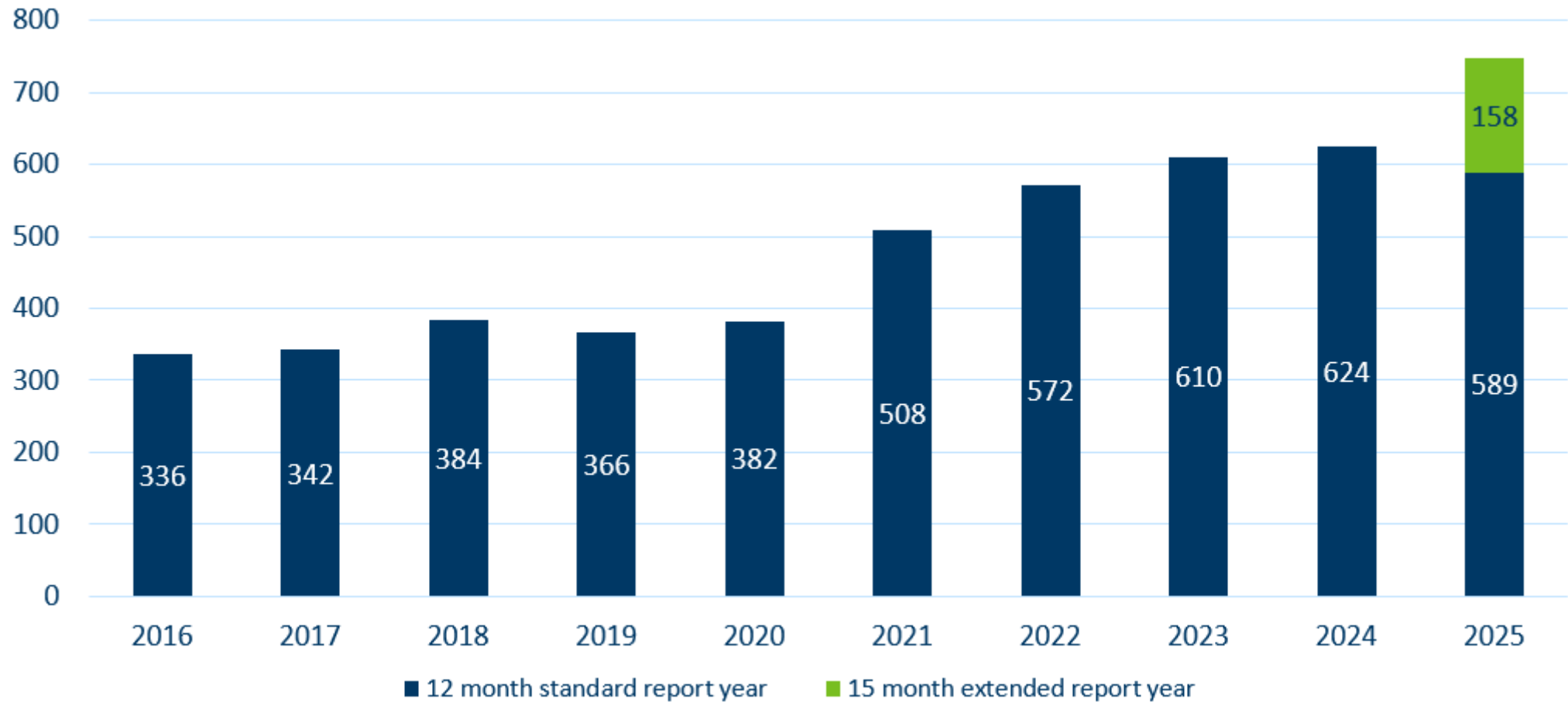
Adverse Health Event Details

- In Minnesota, all hospitals and licensed ambulatory surgical centers are required to report whenever an adverse health event (AHE) occurs and to conduct a root cause analysis to identify the factors that led to the event.
 - Federal hospitals are excluded
- This chartbook covers an extended reporting period: Oct 7th 2024-Dec 31st 2025.
- For a list of reportable events see [Adverse Health Events Reporting Law: Minnesota's 29 Reportable Events \(PDF\)](#)
- Facility level data is available on the MDH website: [Adverse Health Events Reporting](#)

NOTE: Changes to AHE Reporting Dates

- In order to align AHE reporting years with calendar years, this year's report will include data from October 7, 2024 through December 31, 2025.
- This report release will include roughly 15 months of data rather than 12.
- Beginning in calendar year 2026, all AHE reporting year cycles will now begin on January 1 of each year and go through Dec 31 of that same year.

Total Reported Adverse Health Events 2016-2025

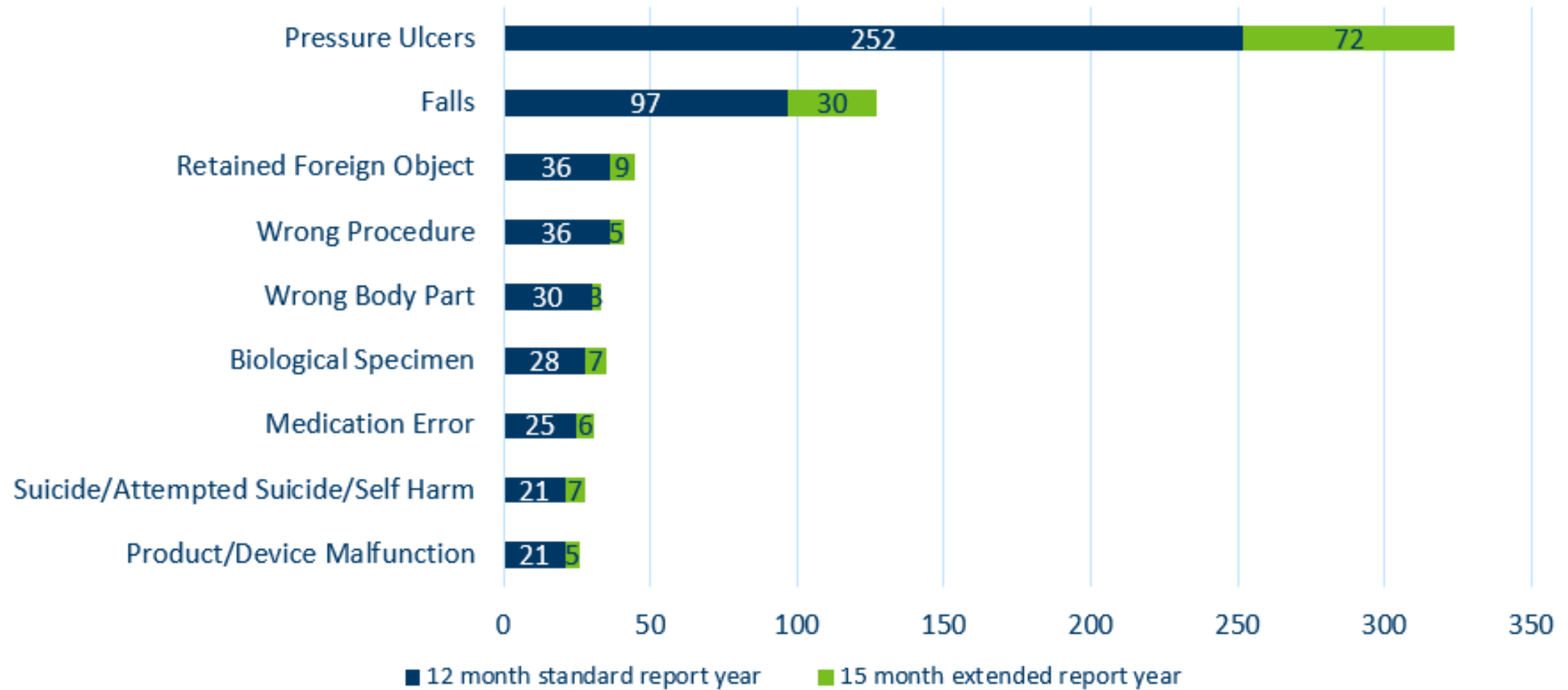


Adverse Health Event Details

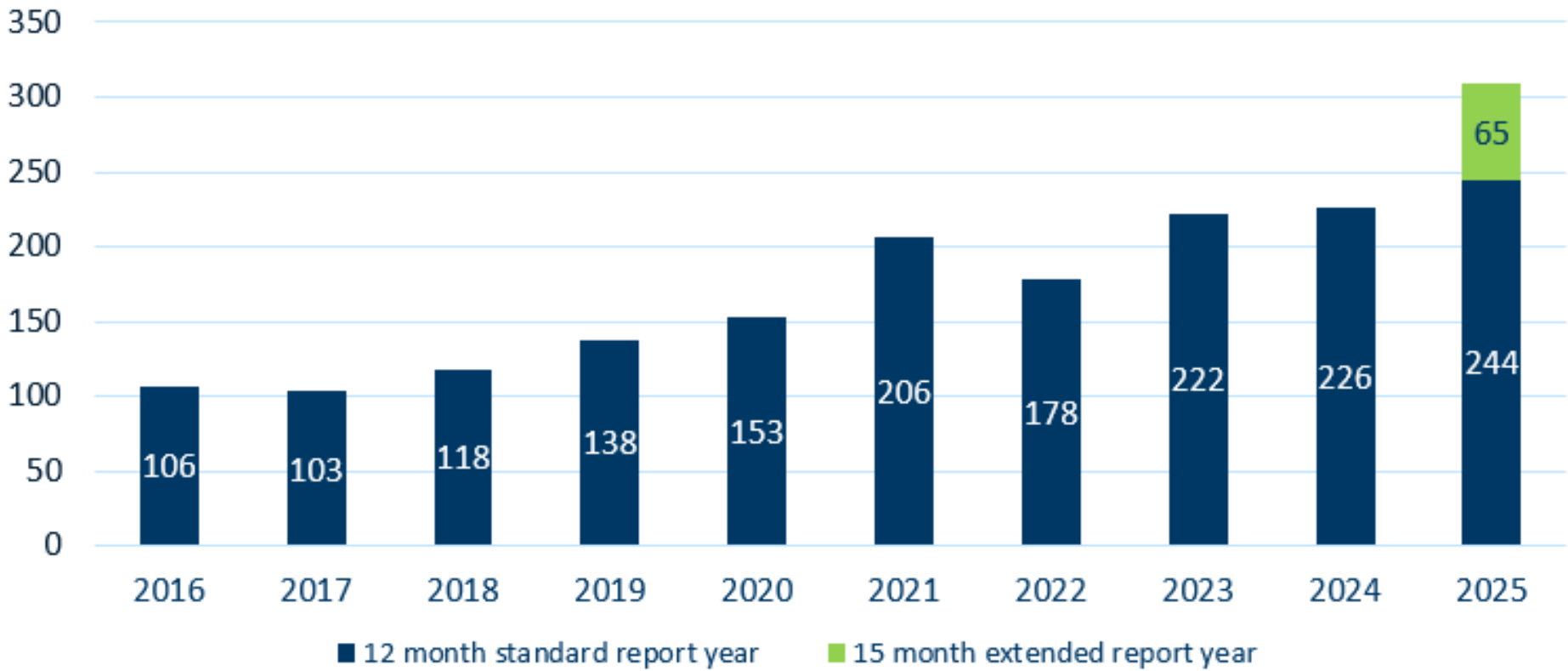
- Key issues or themes for the year:
 - Number of events in the traditional 12-month reporting year dropped from 624 to 589
 - Increase in events resulting in serious injury
 - Pressure injuries (pressure ulcers) continue to represent the largest number of events; however, they did show a decrease this (12-month) reporting year
 - Decrease in biological specimens
 - Decrease in retained foreign objects
 - Continued increase in self-harm events, mostly related to ingestion of foreign objects
 - Increase in medication errors

Adverse Health Events by Category

2025

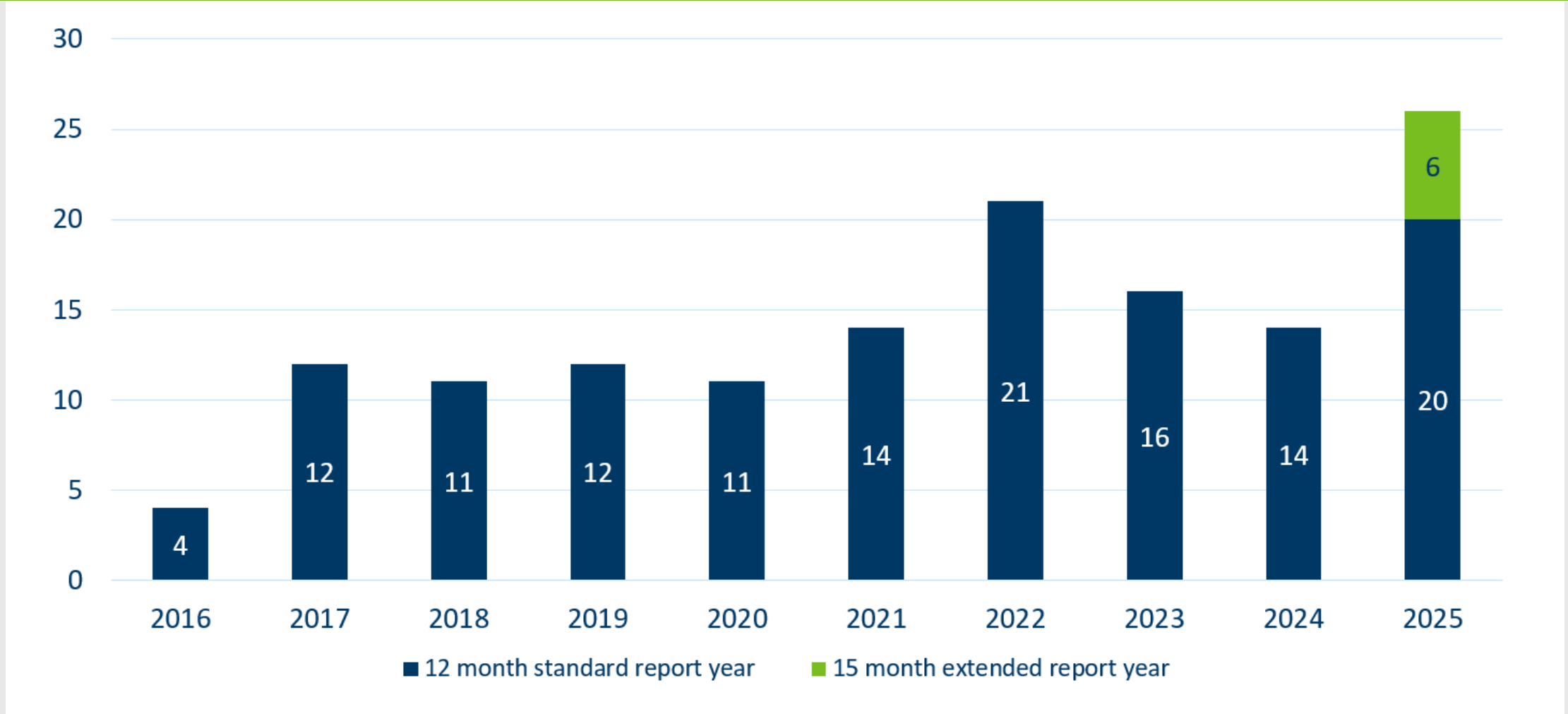


AHE Resulting in Serious Injury 2016-2025



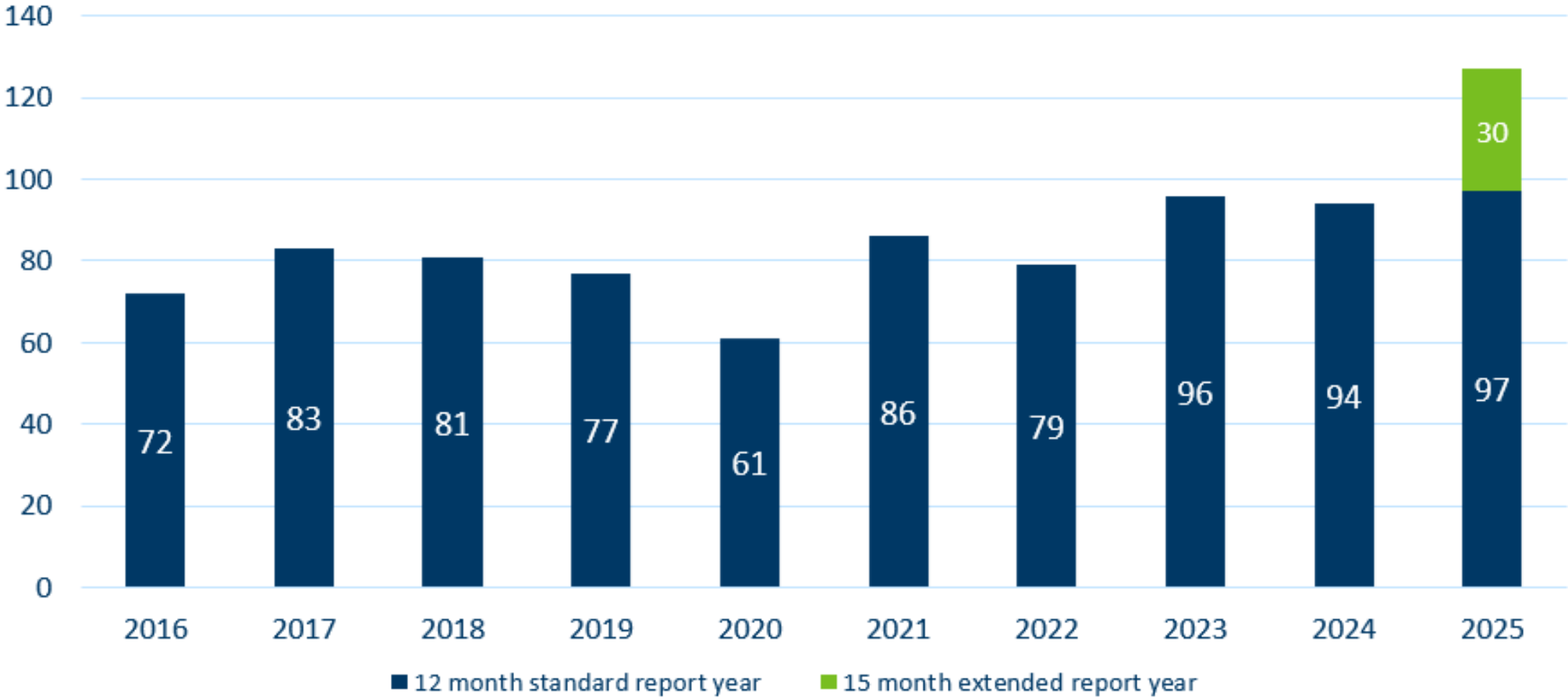
Serious Injury Totals 2025: Falls 116, Pressure Ulcers 51, Suicide/Attempted Suicide/Self Harm 28, Medication Error 25, Product/Device Malfunction 22, Retained Foreign Object 19, Physical Assault 18, Test Results 8, Wrong Body Part Procedure 6, Wrong Procedure 6, Burn 4, Neonatal Labor/Delivery 3, Biological Specimen 1, Maternal Labor 1, Patient Elopement 1.

AHE Resulting in Death 2016-2025



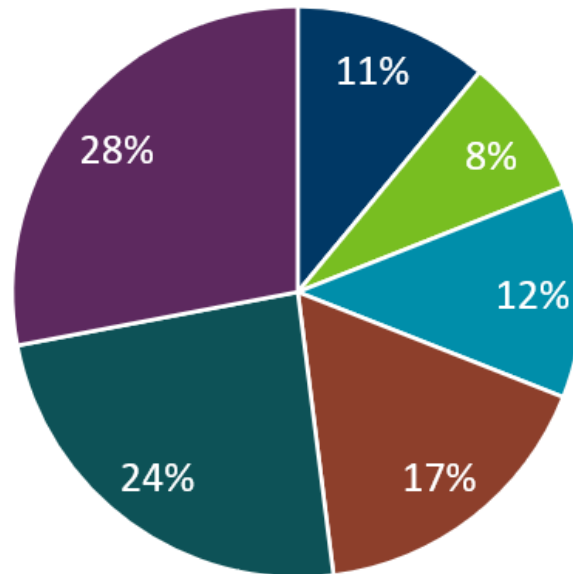
Death totals 2025: Falls 11, Medication Error 6, Product/Device Malfunction 4, Air Embolism 2, Neonate Labor & Deliver 1, Test Results 1, Wrong Body Part Procedure 1.

Reported Falls 2016-2025



Reported Falls Additional Information

Falls Location, 2025



Falls information:

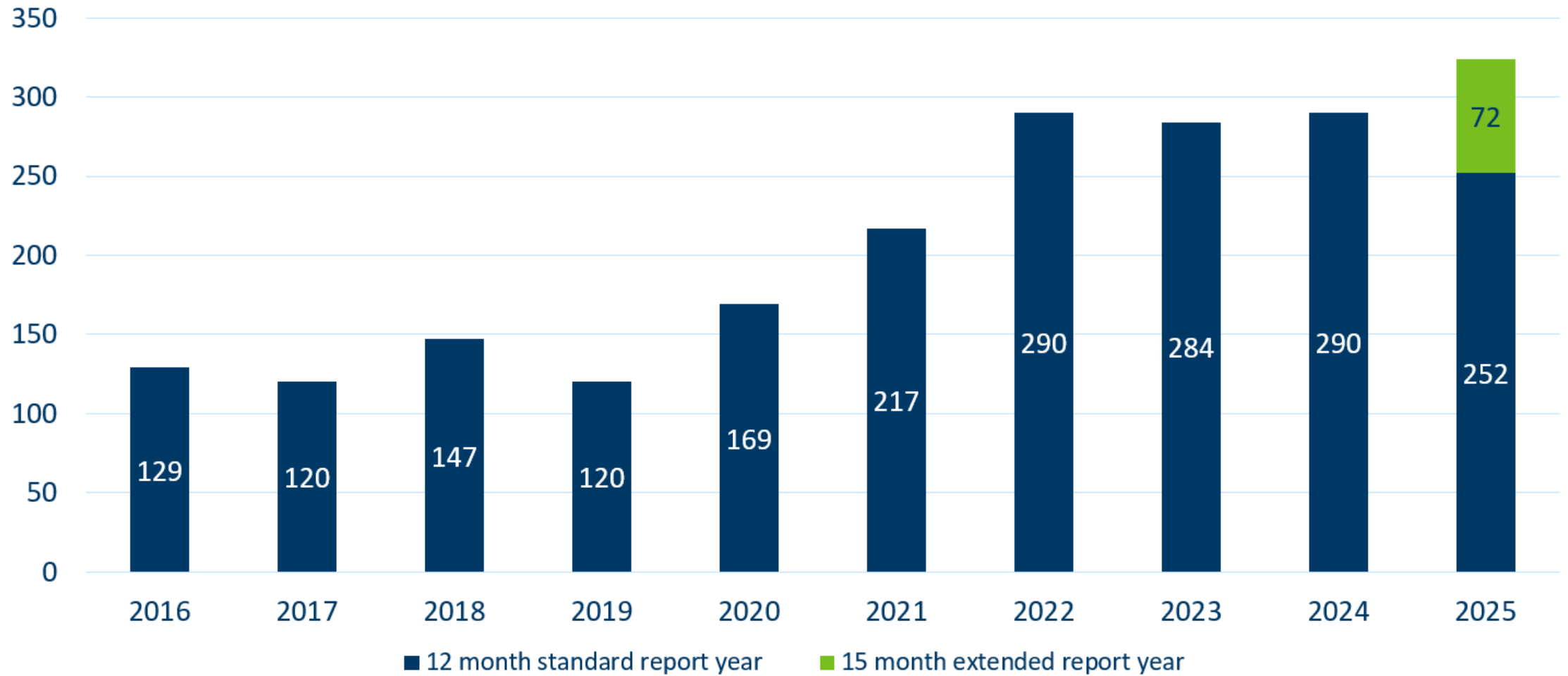
- Continued trend of patients with bed/chair alarms included in care plan, but not in place at the time of the fall.
- Increase in falls in patients with underlying conditions like delirium and mental health issues, as well as patients taking psychoactive medications, which can increase fall risk.

Reported Falls Additional Information

Commonly reported root causes/contributing factors:

- Overestimation by the patient of their ability to walk or use the toilet independently
- Lack of process on how to handle when patient fall risk changes mid-shift
- Not using bed/chair alarms when risk assessment indicated a need
- Lack of communication of patient history of falls
- Inconsistent risk assessments, the full risk is not always appreciated
- Patient's desire for privacy vs. staff staying within arms reach during toileting
- Equipment availability and/or effectiveness (lifts, floor mats, chair/bed alarms)

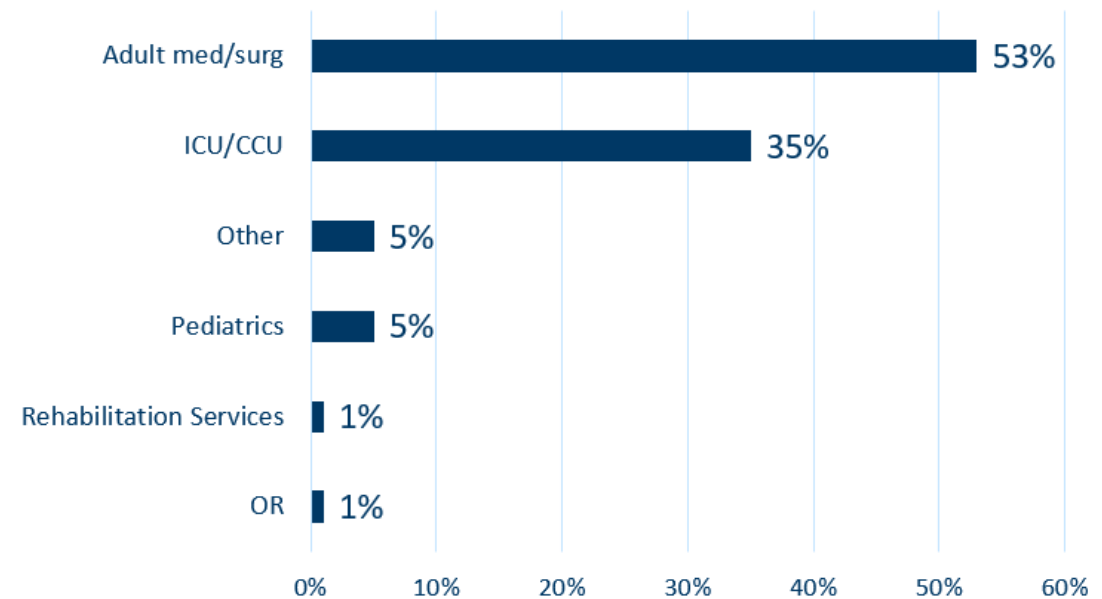
Reported Pressure Injuries 2016-2025



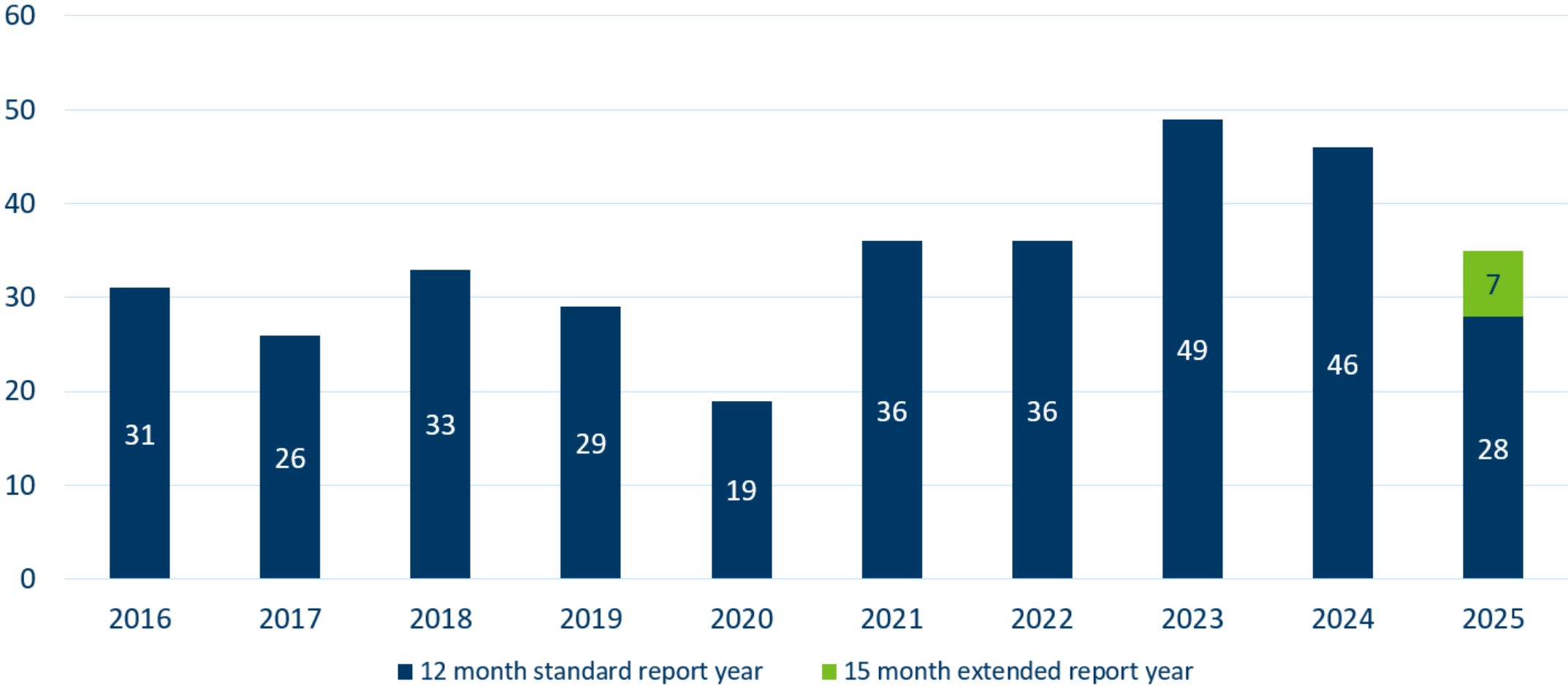
Reported Pressure Ulcers Additional Information

- Pressure ulcer severity
 - Treatment required 66%
 - Monitoring required 19%
 - Serious injury 15%
- Most common areas of pressure ulcer development
 - Coccyx
 - Sacrum
 - Heel/feet

Pressure Ulcer Event Location, 2025



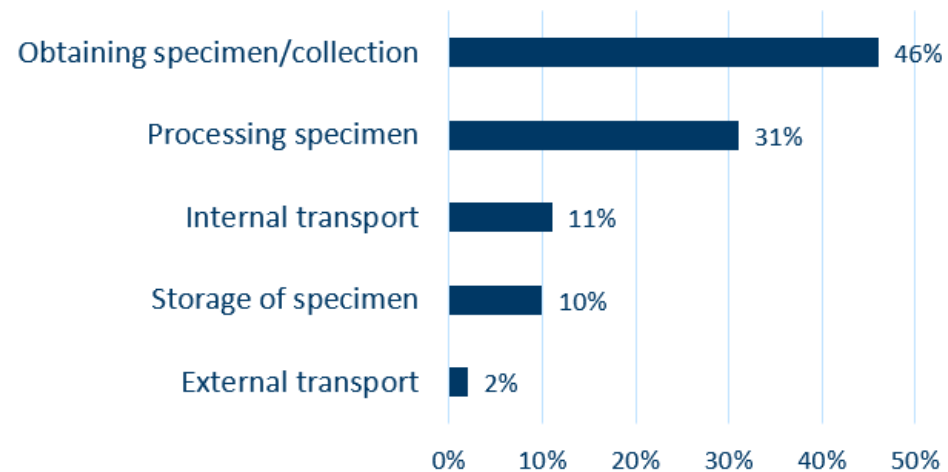
Reported Biological Specimen Events 2016-2025



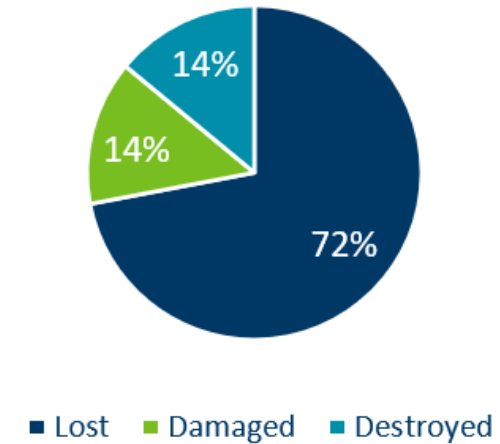
Reported Biological Specimen Events Additional Information

Most common type of lost/destroyed specimen: placentas and colon polyps

Where Loss/Damage Occurred, 2025



Specimen State, 2025

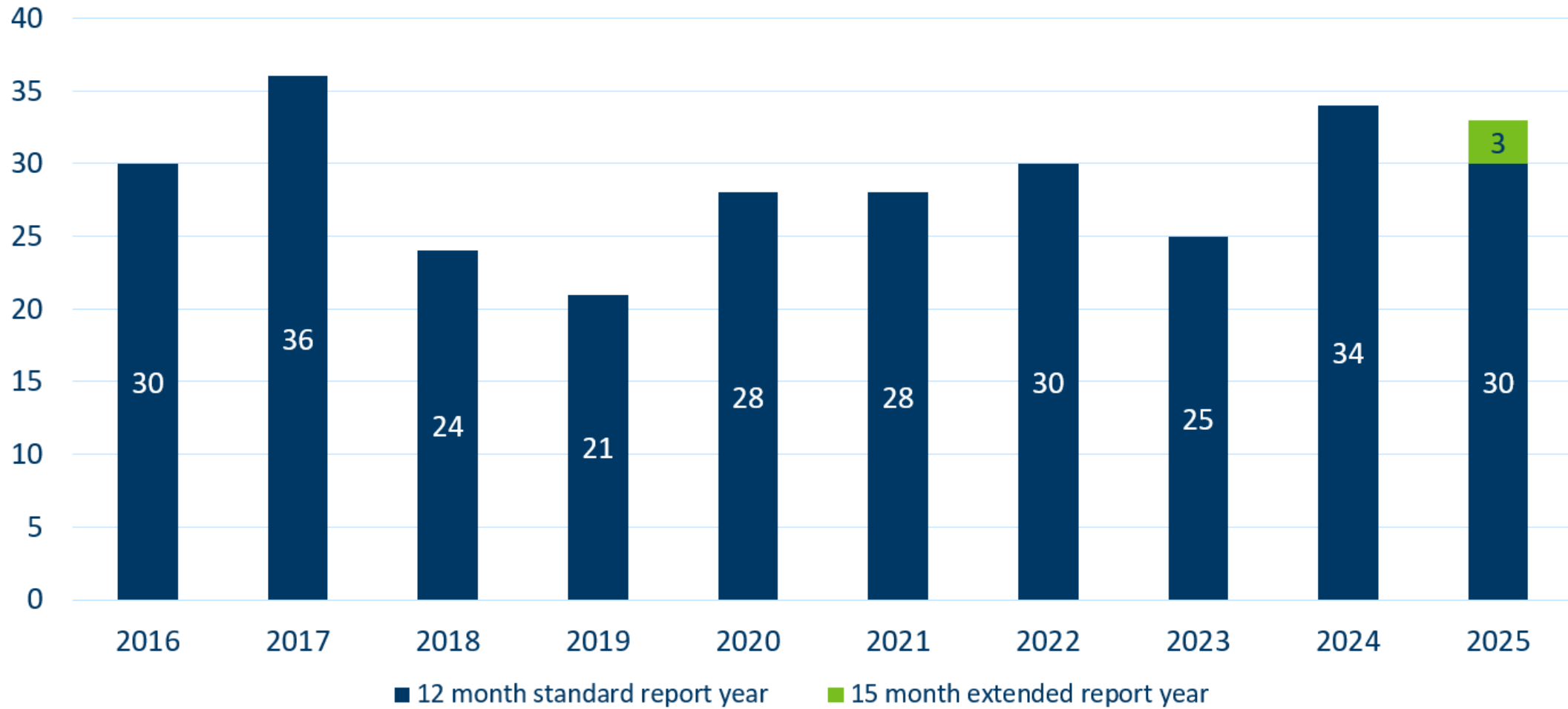


Reported Biological Specimen Events Additional Information

Commonly reported root causes/contributing factors:

- Drift in practice with chain of custody of samples
- Lack of debrief after the procedure to assure all specimens were accounted for
- Lack of process to track all specimens removed from body
- Double checks and visualizations often not completed to verify sample captured was correct, number of samples collected correct etc.

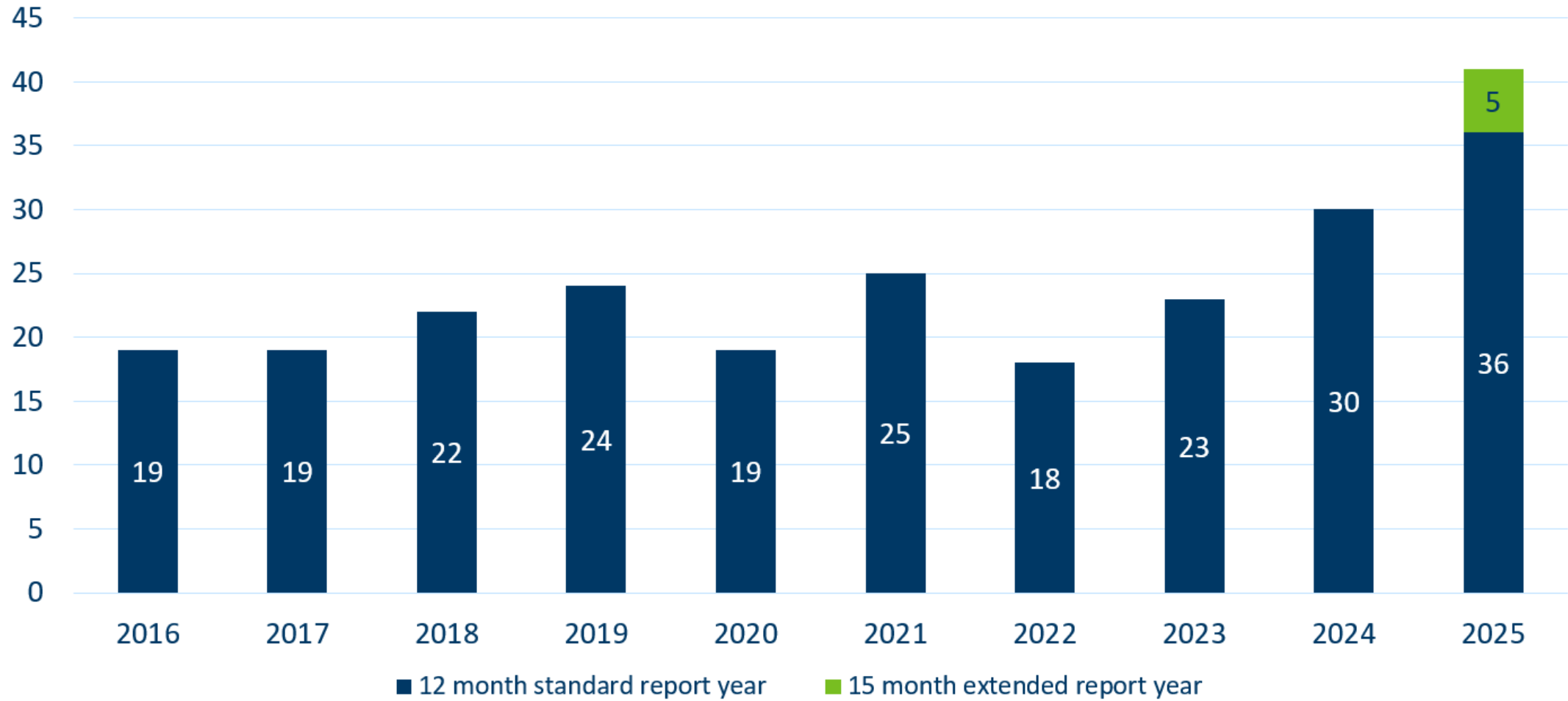
Wrong Body Part Procedure Events 2016-2025



Wrong Body Part Procedure Events Additional Information

- Definition of wrong body part surgery/procedure:
 - Surgery or other invasive procedure performed on a wrong body part that is not consistent with the documented informed consent for that patient.
- Most common types of wrong body part procedures:
 - Wrong side (e.g. left vs. right)
 - Spine
 - Orthopedic
 - Urology

Wrong Procedure Events 2016-2025



Wrong Procedure Events Additional Information

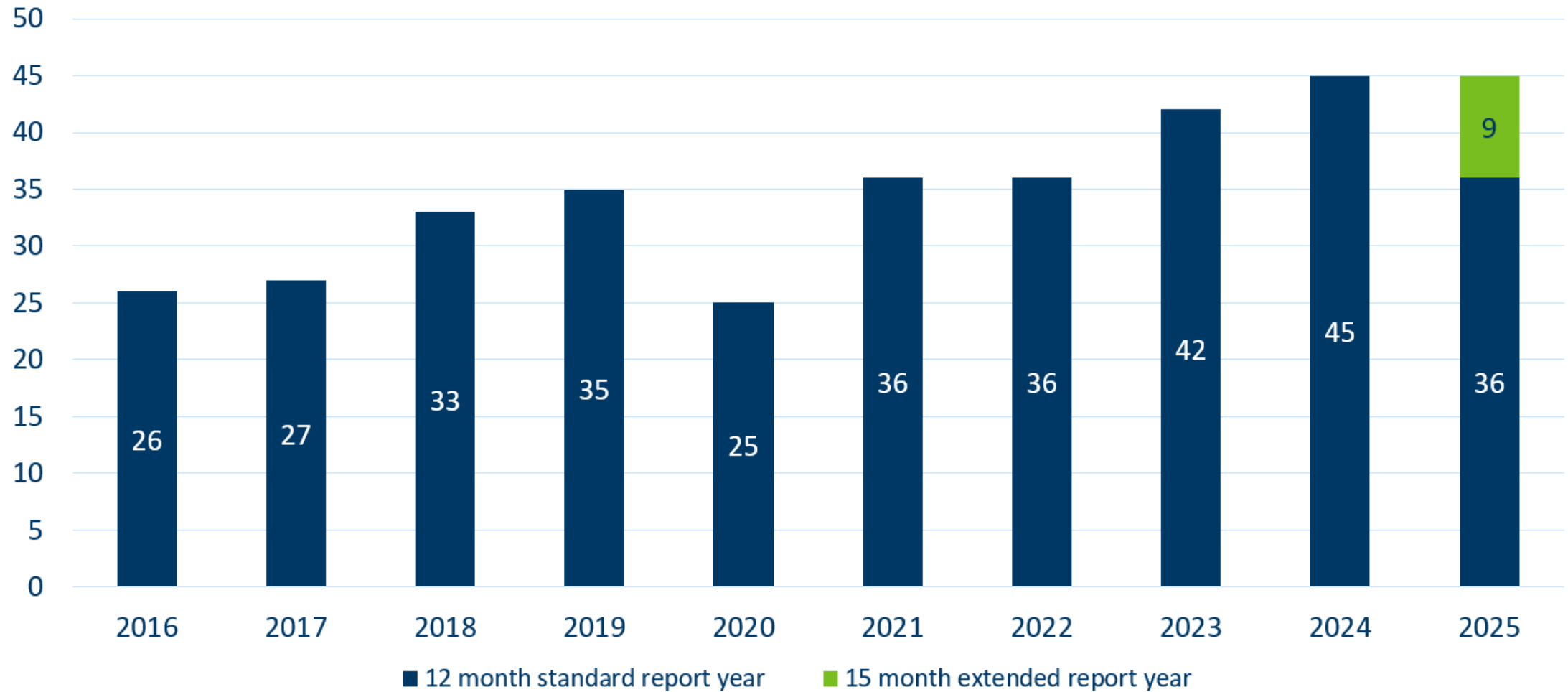
- Definition of wrong procedure:
 - The wrong surgical or other invasive procedure performed on a patient that is not consistent with the documented informed consent for that patient.
- Most Common types of reported wrong procedure events:
 - Eye procedures (incorrect implant placed)
 - Orthopedics
 - Gynecology

Wrong Body Part/Wrong Procedure

Commonly reported root causes/contributing factors:

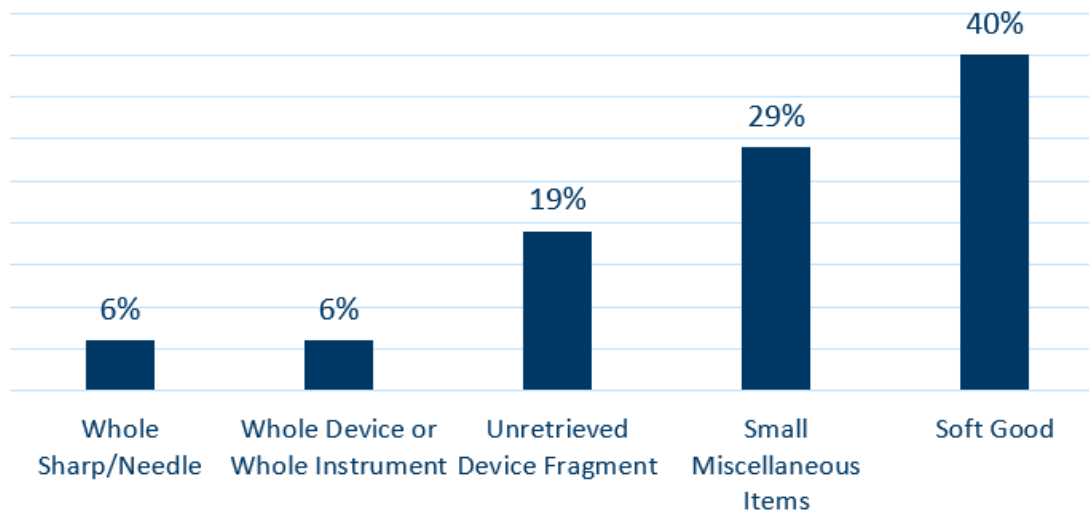
- Drift in Time Out process
 - Lack of order verification
 - Failure to confirm procedure on the informed consent document
 - Laterality not confirmed
 - Lack of proper source documents
- Lack of communication during staff turnover during the procedure
- Unique patient anatomical differences not accounted for

Retained Foreign Objects 2016-2025



Retained Foreign Objects Additional Information

**Types of Retained Foreign Objects
2025**



Trends/Patterns

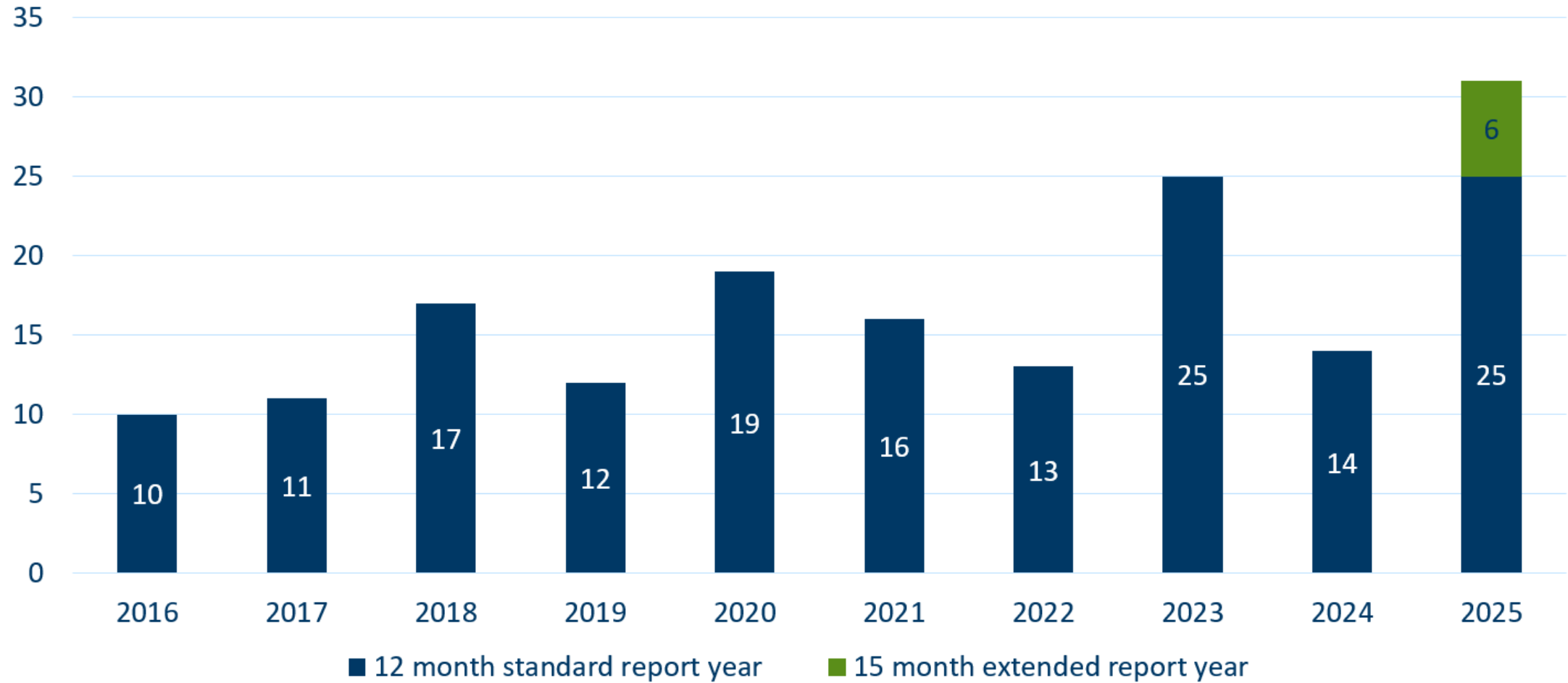
- Procedure Location
 - 49% operating room
 - 19% ambulatory surgery
 - 10% emergency department
- 40% were packed items intended to be removed at a later time, but not removed as intended
- 15% were broken items

Retained Foreign Objects Additional Information

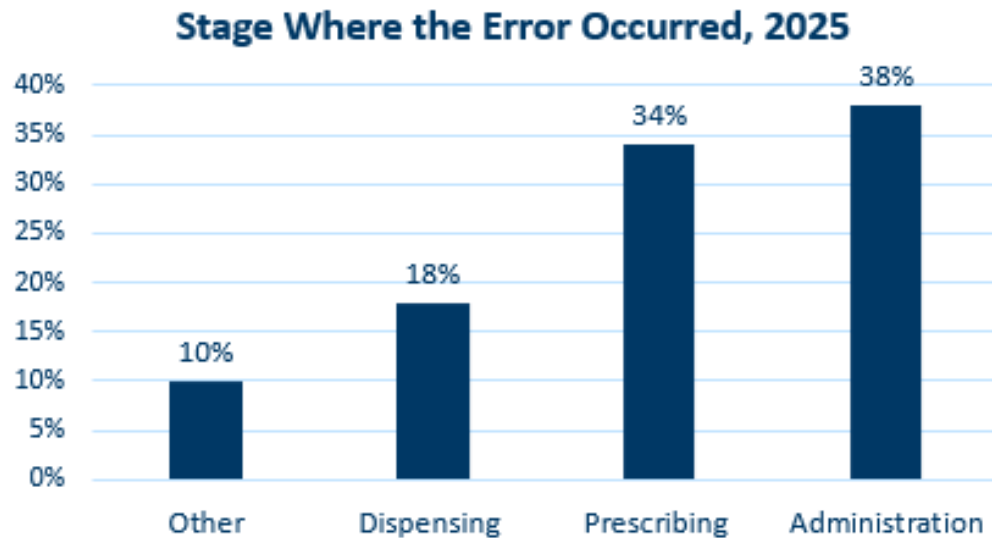
Commonly reported root causes/contributing factors:

- Drift in rigor for the count of items, specifically not following the procedure/policy in place for counting of items
- Lack of communication with interdepartmental teams
- Missing packed items that were intended to be removed after the procedure and before discharge
 - Communication breakdown between staff
 - Missing orders to remove packing or other devices or lack of standard process for writing those orders

Reported Medication Errors 2016-2025



Medication Errors Additional Information



Trends/Patterns

- 10% of cases involved verbal orders
- In 22% of cases there was not a medication reconciliation done
- In 25% of cases the EHR (electronic health record) or other technology, played a role in the event

Next Steps

- In the upcoming year, MDH and its partners will:
 - Work with reporting facilities around adherence to best practices for reducing falls and self-harm events
 - MHA will convene clinical quality committees to discuss trends in adverse events throughout the report year and identify best practices to improve patient care
 - MHA is hosting a two-day, in-person conference for hospital and health systems to share and learn about best practices related to quality and safety
 - Work to streamline shared learnings and best practices for our hospitals, ambulatory surgery centers and health systems

Additional Information from the Adverse Health Events Program Available Online

- [Adverse Health Events](https://www.health.state.mn.us/facilities/patientsafety/adverseevents/index.html)
(<https://www.health.state.mn.us/facilities/patientsafety/adverseevents/index.html>)
- Searchable Database for Facility Specific Data
[Adverse Health Events Reporting](https://www.health.state.mn.us/facilities/patientsafety/adverseevents/adverseselect.html)
(<https://www.health.state.mn.us/facilities/patientsafety/adverseevents/adverseselect.html>)
- [Minnesota's 29 Reportable Events](https://www.health.state.mn.us/facilities/patientsafety/adverseevents/adverseevents.html)
(<https://www.health.state.mn.us/facilities/patientsafety/adverseevents/adverseevents.html>)
- [MN Statutes 144.7065](https://www.revisor.mn.gov/statutes/cite/144.7065) (<https://www.revisor.mn.gov/statutes/cite/144.7065>)
- [Adverse Health Events Reporting Law: Minnesota's 29 Reportable Events \(PDF\)](#)