DEPARTMENT OF HEALTH

Adverse Health Events Chartbook
June 2025

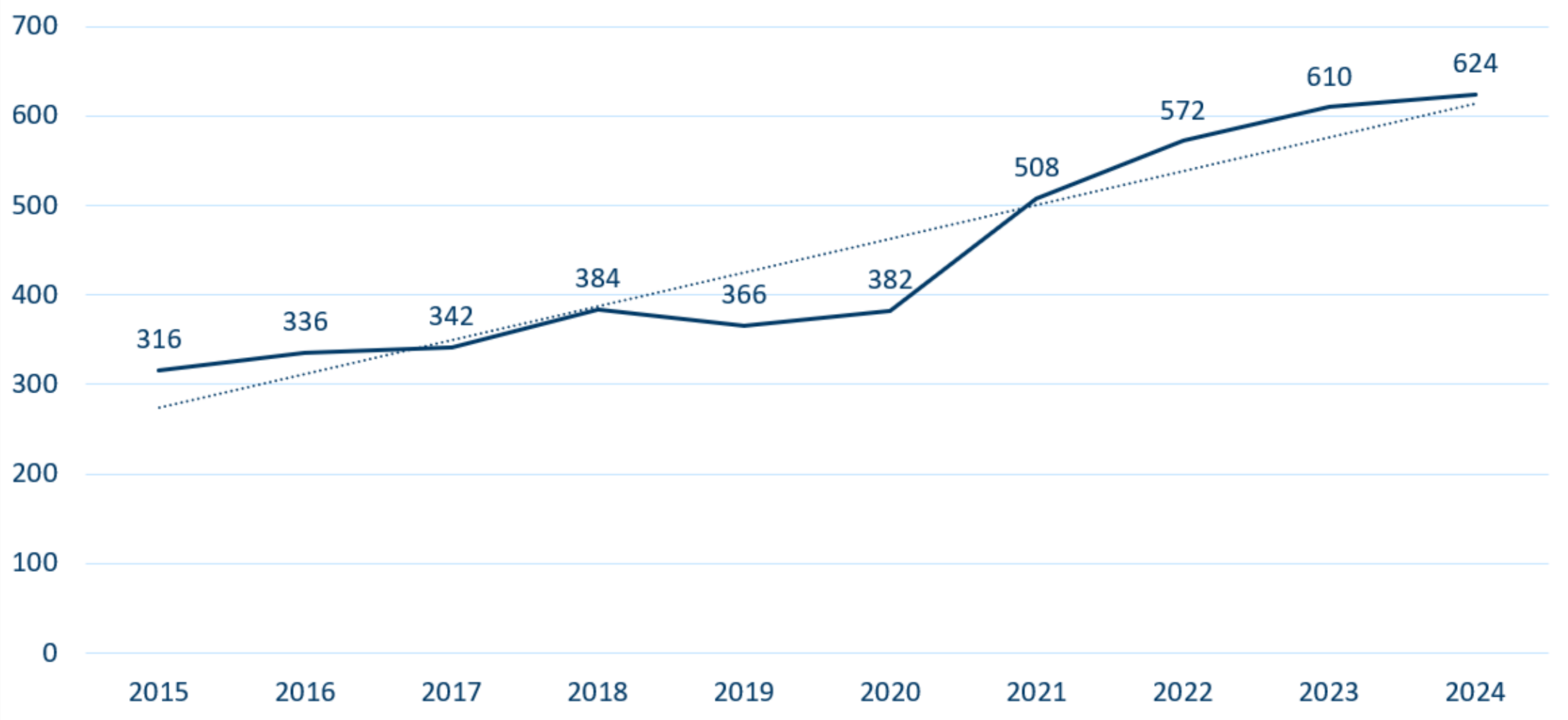
Adverse Health Event Details

- 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 the reporting period Oct 7th, 2023-Oct 6th, 2024
- For a list of reportable events see Minnesota's 29 Reportable Adverse Health Events
- Facility level data is available on the Adverse Health Events Reporting

NOTE: Changes to AHE Reporting Dates

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

Total Reported Adverse Health Events 2015-2024

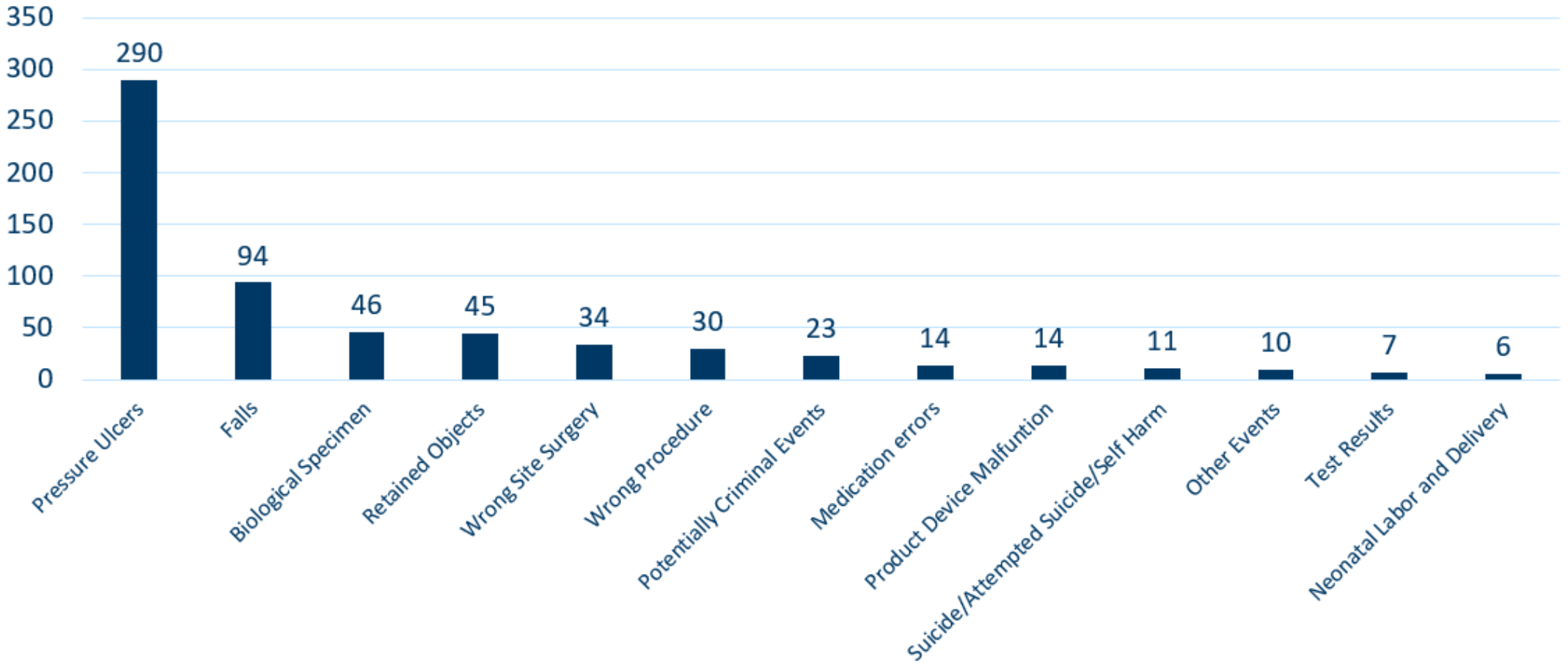


Note: During the 2024 reporting period, total inpatient & outpatient surgeries/procedures = 621,205 (up from 572,031)

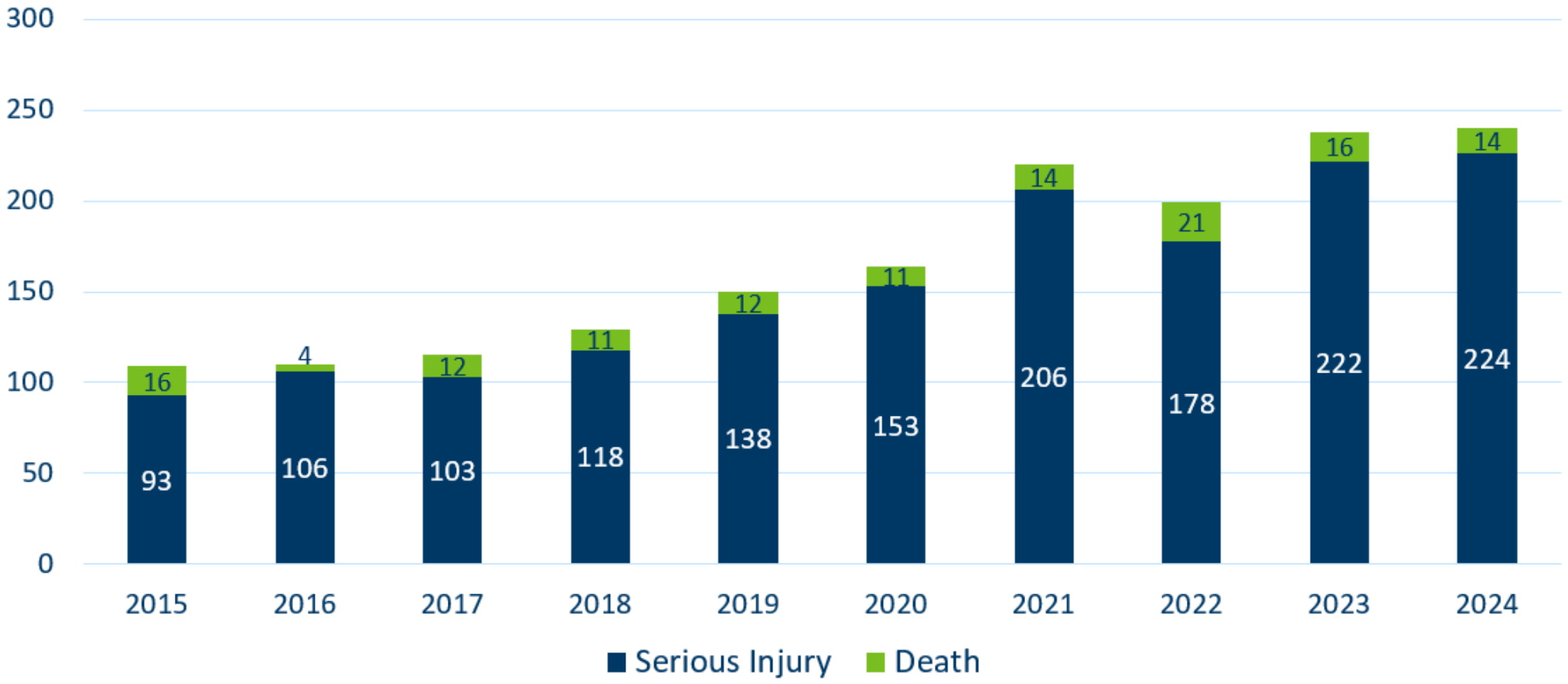
Adverse Health Event Themes

- Key issues or themes for the year:
  - Number of events rose to 624 from 610
  - Pressure injuries continue to represent the largest number of events
    - Increased number of patients declined repositioning
    - Increased number of patients with conditions susceptible to pressure injuries (e.g. ECMO)
  - Increase in wrong body part and wrong procedures from previous year
    - Noted increase in total surgeries performed 621,205 (up from 572,031)
  - Decrease in biological specimens for the first time since 2020
  - Decrease in medication errors (44% decrease from previous year)
  - Continued increase in self-harm events, mostly related to ingestion of foreign objects

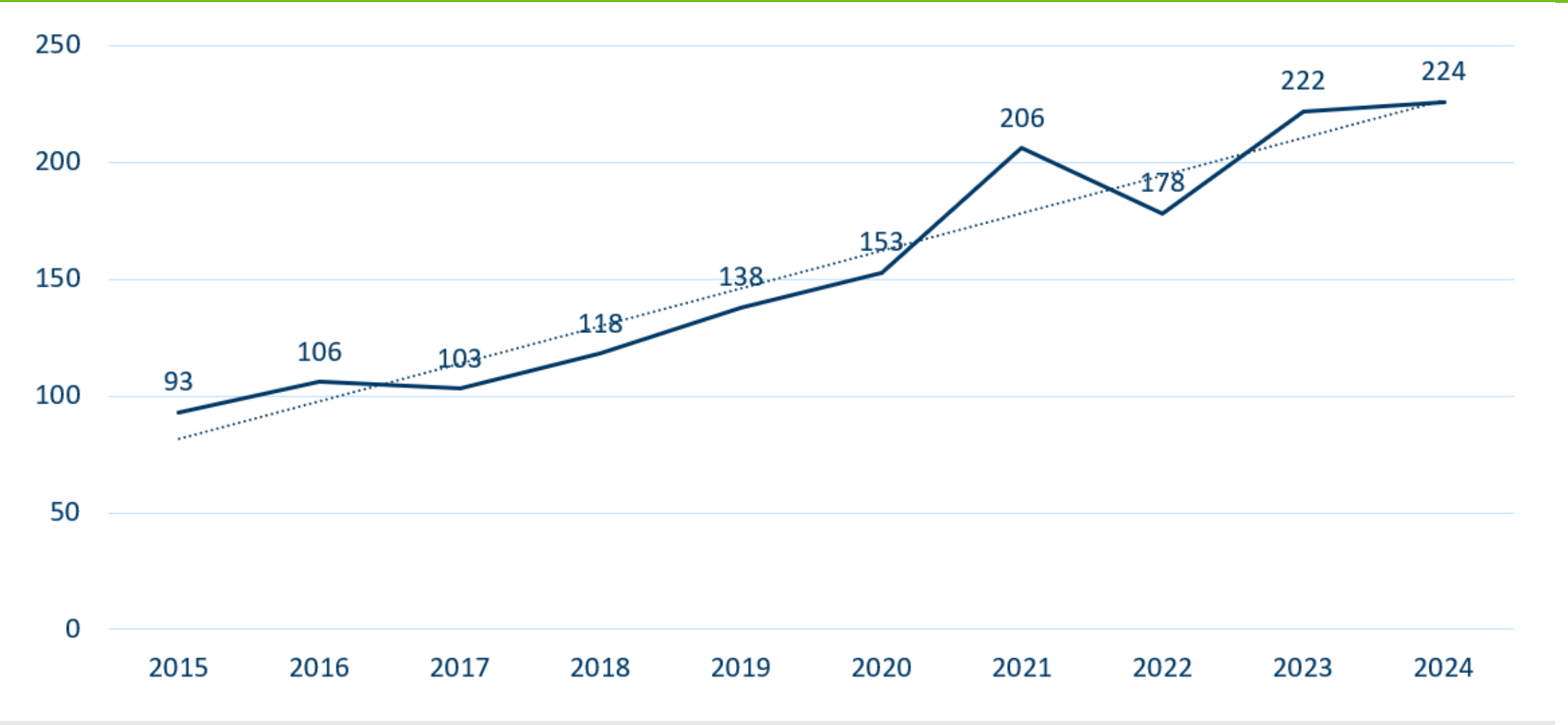
Adverse Health Events by Category 2024



AHE Injury Severity 2015-2024

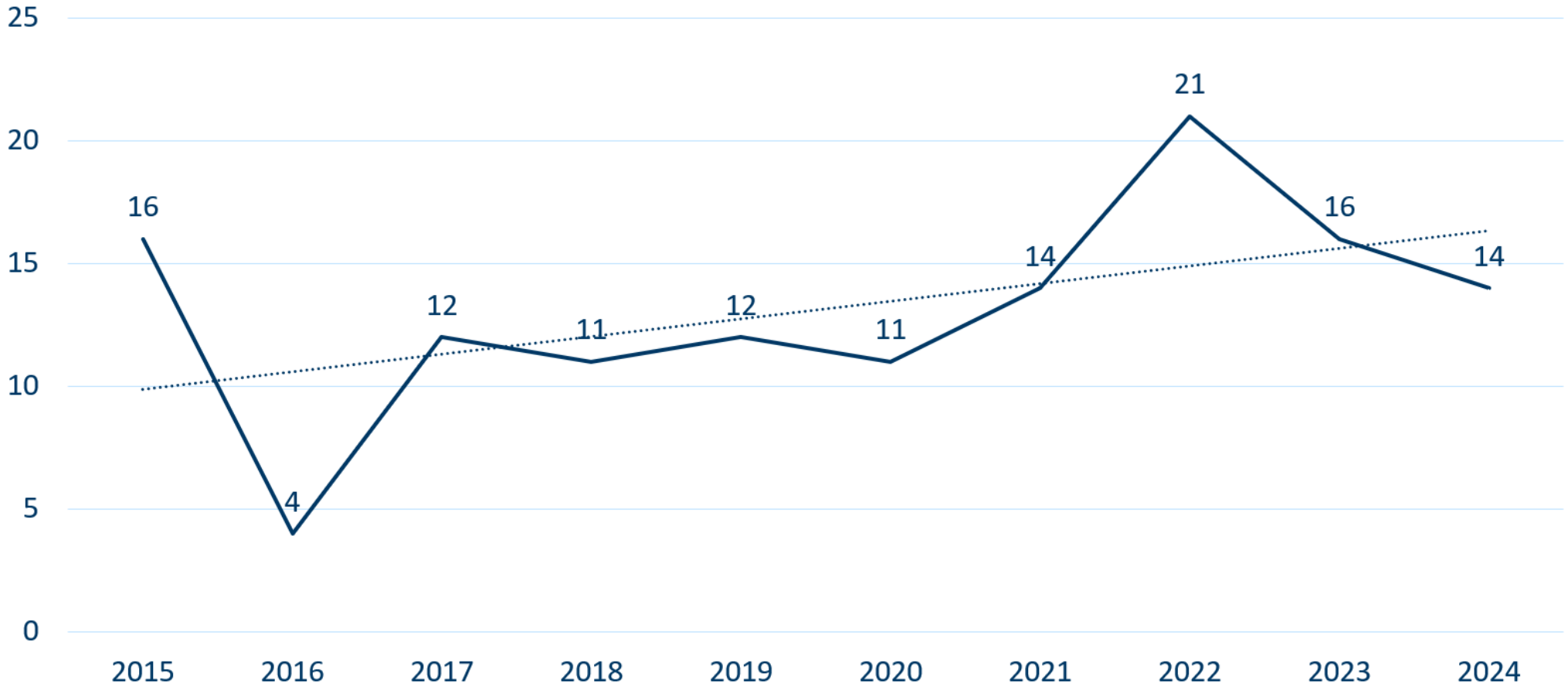


AHE Resulting in Serious Injury 2015-2024



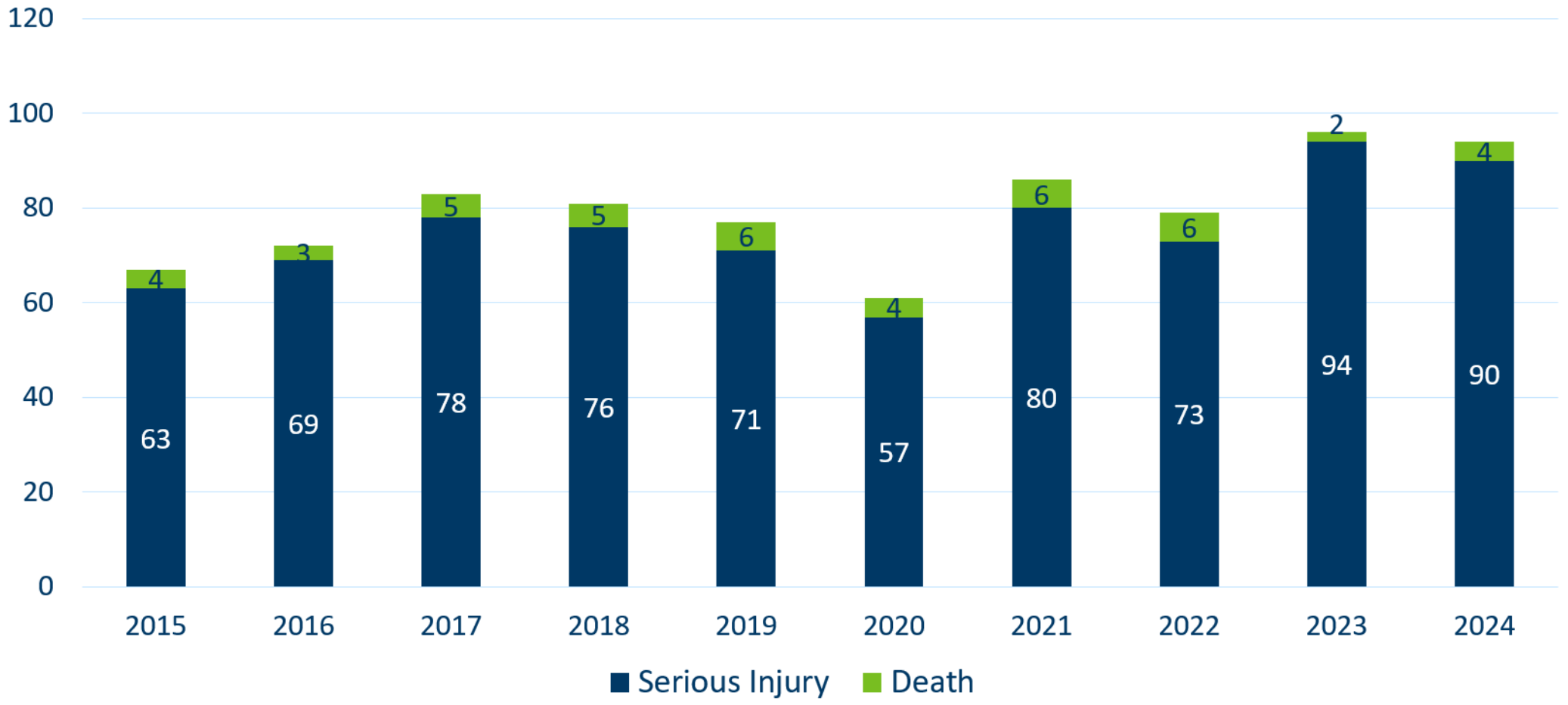
Serious Injury Totals 2024: Falls 90, Pressure Ulcers 34, Retained Foreign Object 24, Physical Assault 16, Medication Error 13, Suicide/Attempted Suicide/Self Harm 11, Product/Device Malfunction 10, Wrong Procedure 6, Test Results 6, Wrong Body Part Procedure 4, Burn 3, Neonatal Labor/Delivery 3, Air Embolism 1, Patient Elopement 1, Restraints 1, Biological Specimen, 1

AHE Resulting in Death 2015-2024

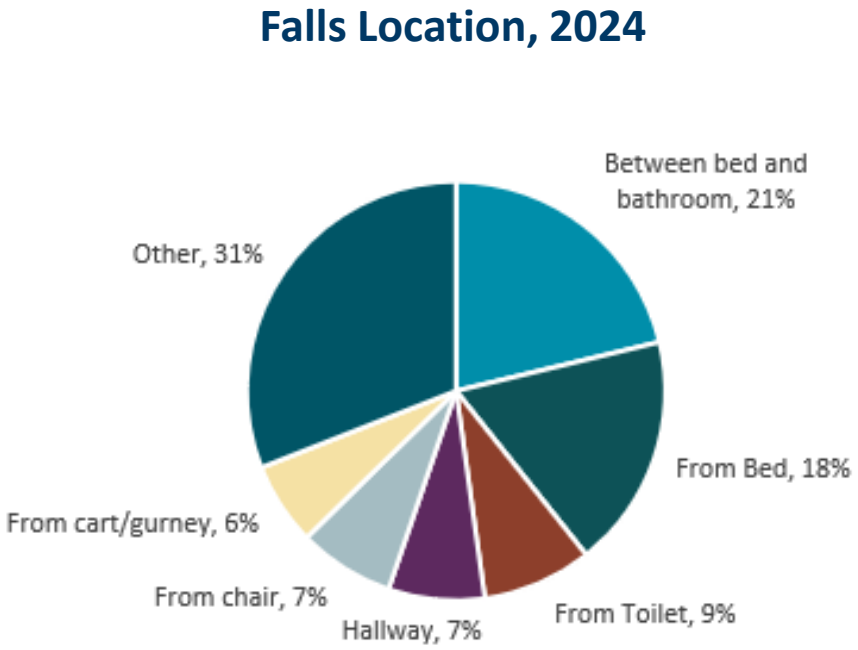


Death totals 2024: Product/Device Malfunction 4, Fall 4, Neonate Labor & Deliver 3, Elopement 1, Test Results 1, Medication Error 1

Reported Falls 2015-2024



Reported Falls Additional Information



Falls information:

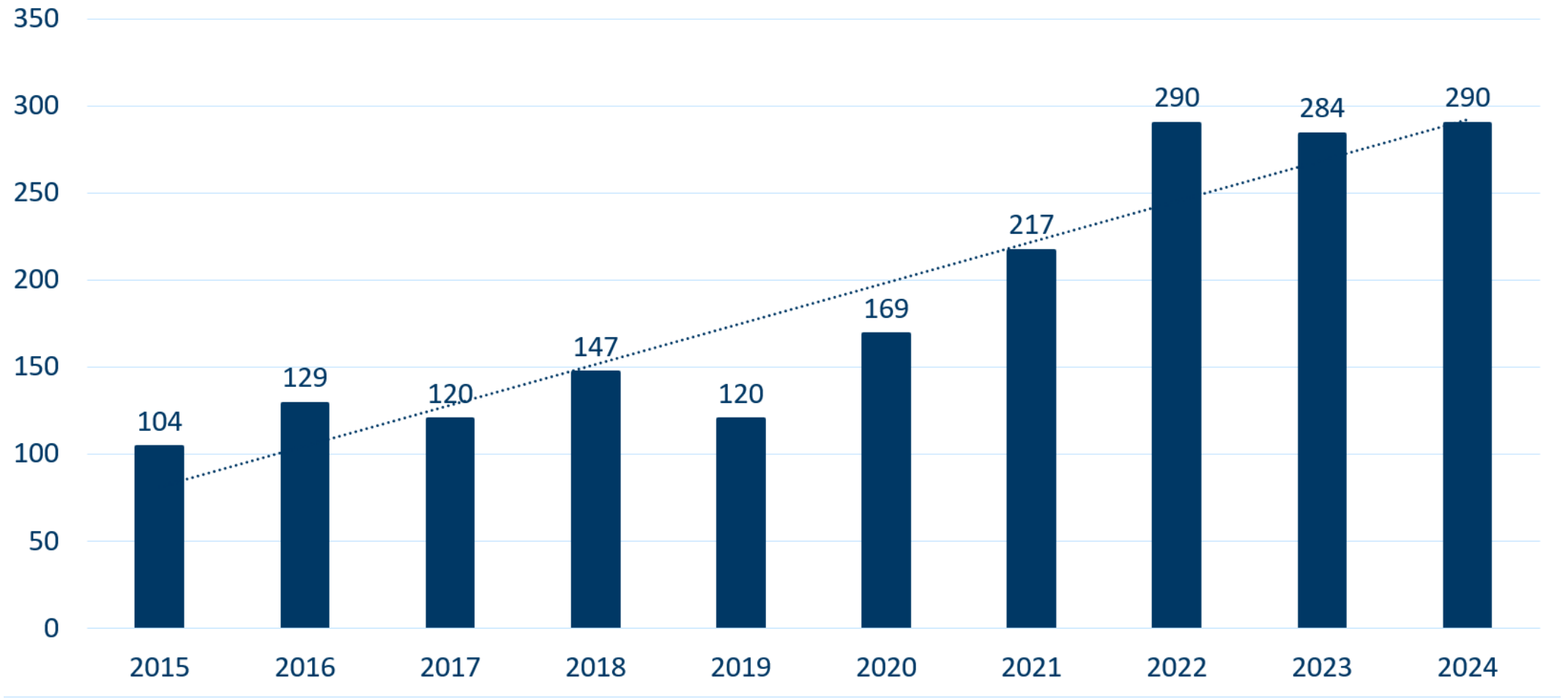
- 46% of falls were toileting related
  - Most commonly was an overestimation by the patient of their ability to toilet independently
- 34% of patients who fell had a bed alarm/chair alarm indicated on their care plan, only 24% of those patients had the bed/chair alarm in place at the time of the fall

Reported Falls
Additional Information Cont.

Commonly reported root causes/contributing factors:

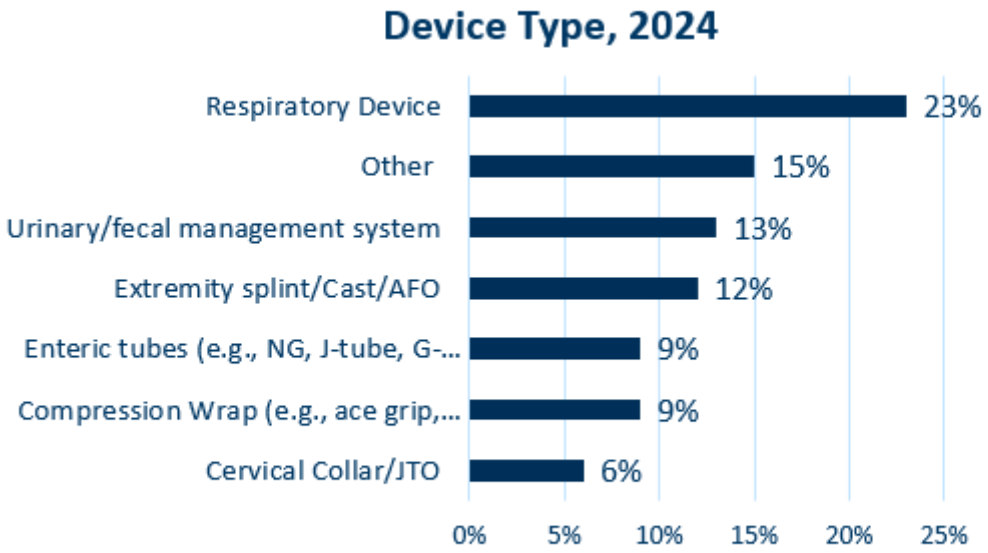
- Unclear policies or procedures around risk screening for falls
- Overestimation by the patient of their ability to toilet independently
- Fall prevention measures not in place when risk assessment indicated a need
- History of falling or fall risk not communicated between staff
- Patient’s desire for privacy vs. staff staying within arms reach during toileting
- Equipment availability and/or effectiveness (lifts, floor mats, chair alarms)
- 30% of reported falls did not have a root cause finding

Reported Pressure Ulcers 2015-2024

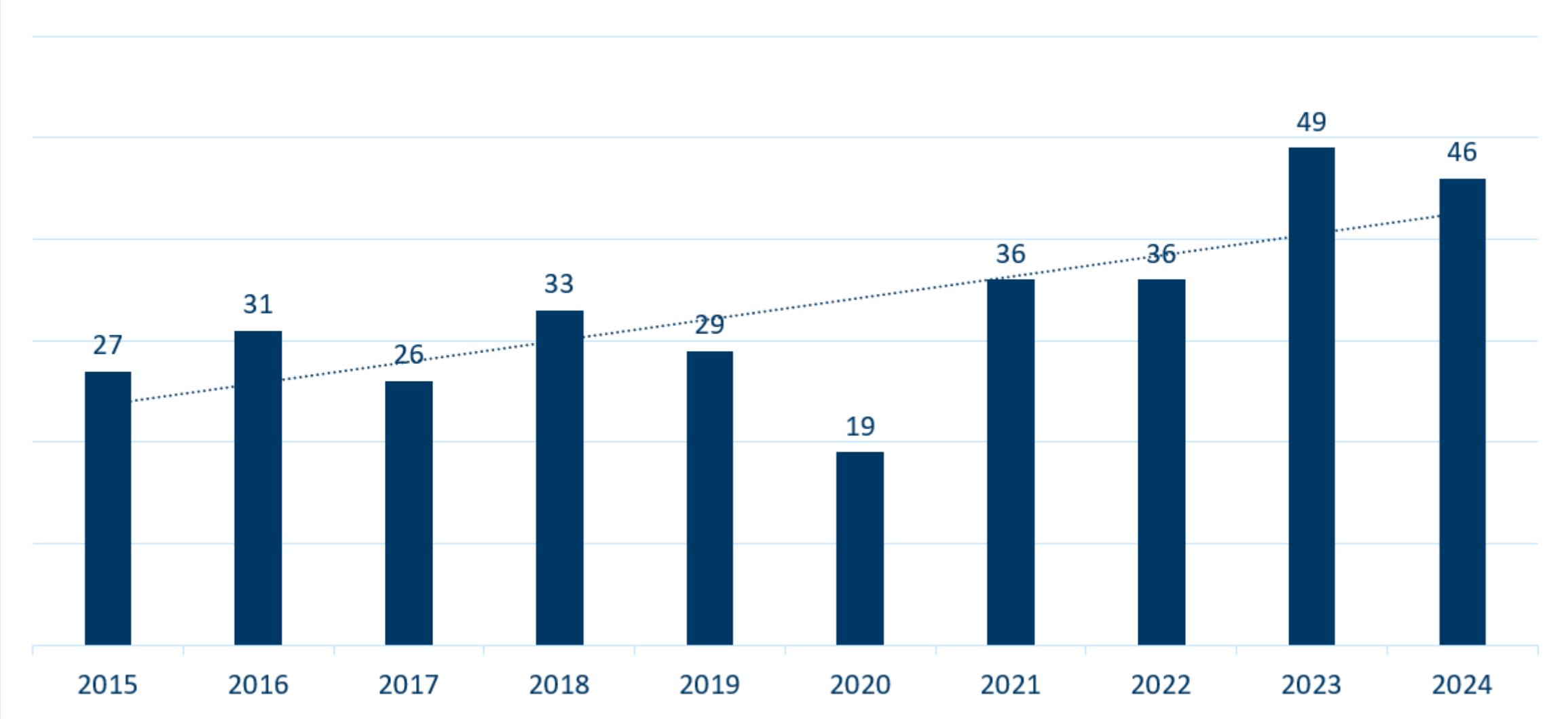


Reported Pressure Ulcers Additional Information

- Pressure ulcer severity
  - Treatment required 69%
  - Monitoring required 17%
  - Serious injury 14%
- Most common areas of pressure ulcer development
  - Coccyx
  - Sacrum
  - Heel/feet
- Thirty percent of reported pressure ulcers were related to medical devices



Reported Biological Specimen Events 2015-2024

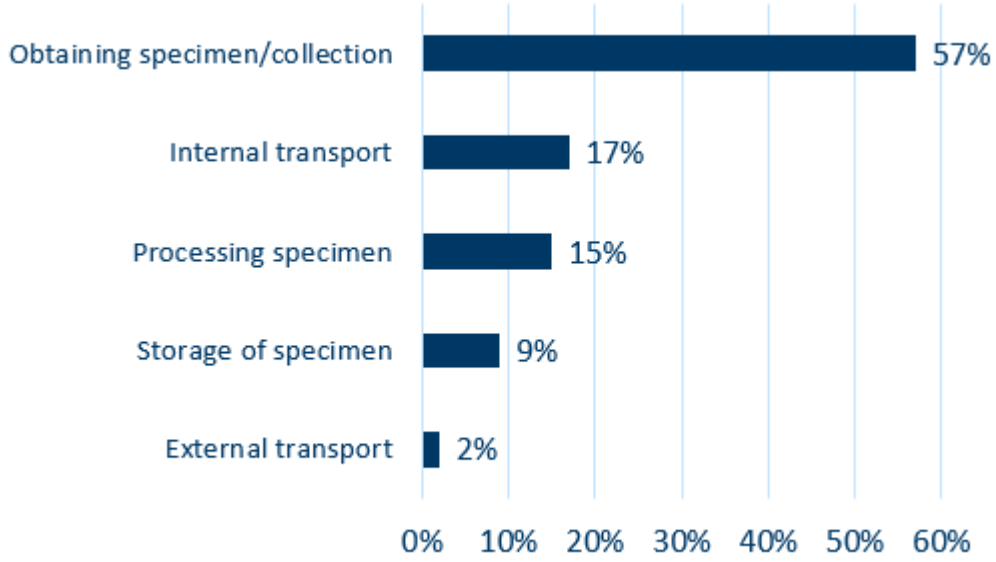


Note: This event was reportable starting in 2015.

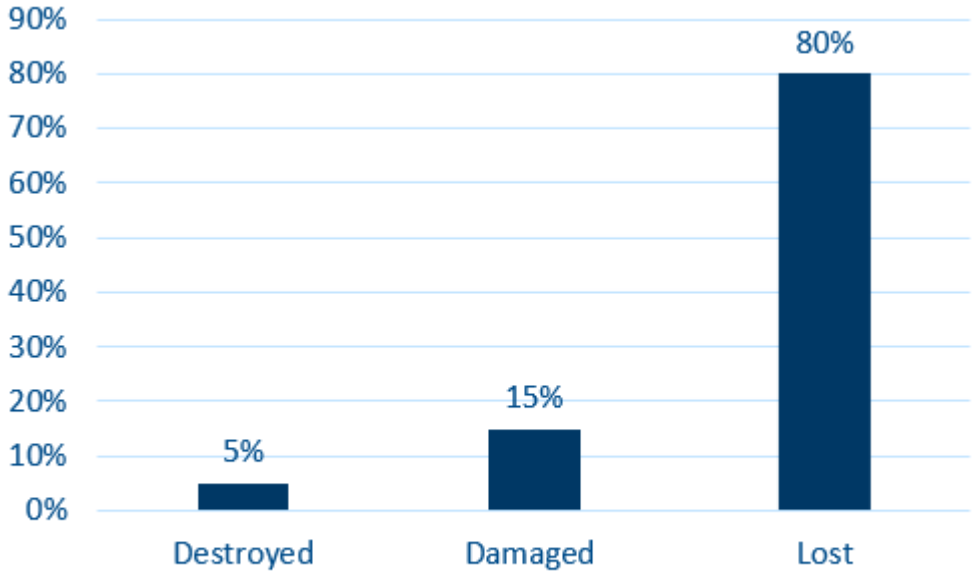
Reported Biological Specimen Events Additional Information

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

Where Loss/Damage Occurred, 2024



Specimen State, 2024

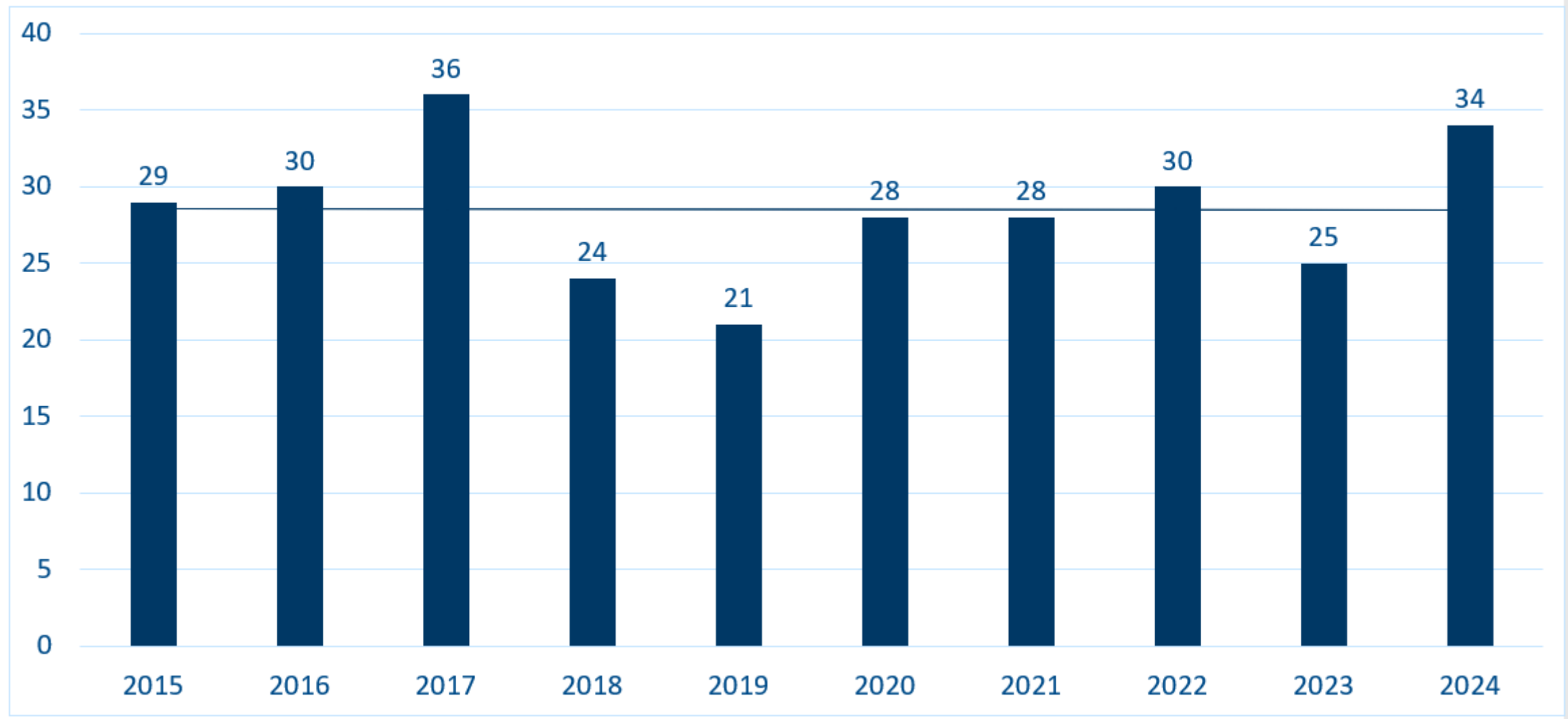


Reported Biological Specimen Events Additional Information Cont.

Commonly reported root causes/contributing factors

- Drift in practice with specimen collection process
- No defined area for specimens in the procedure room
- Lack of post-procedure debrief
- Lack of process to track all specimens removed from body
- No direct handoff from procedure staff to lab staff (often using a courier)
- Issues with locating specimen orders in the EHR

Wrong Body Part Procedure Events 2015-2024

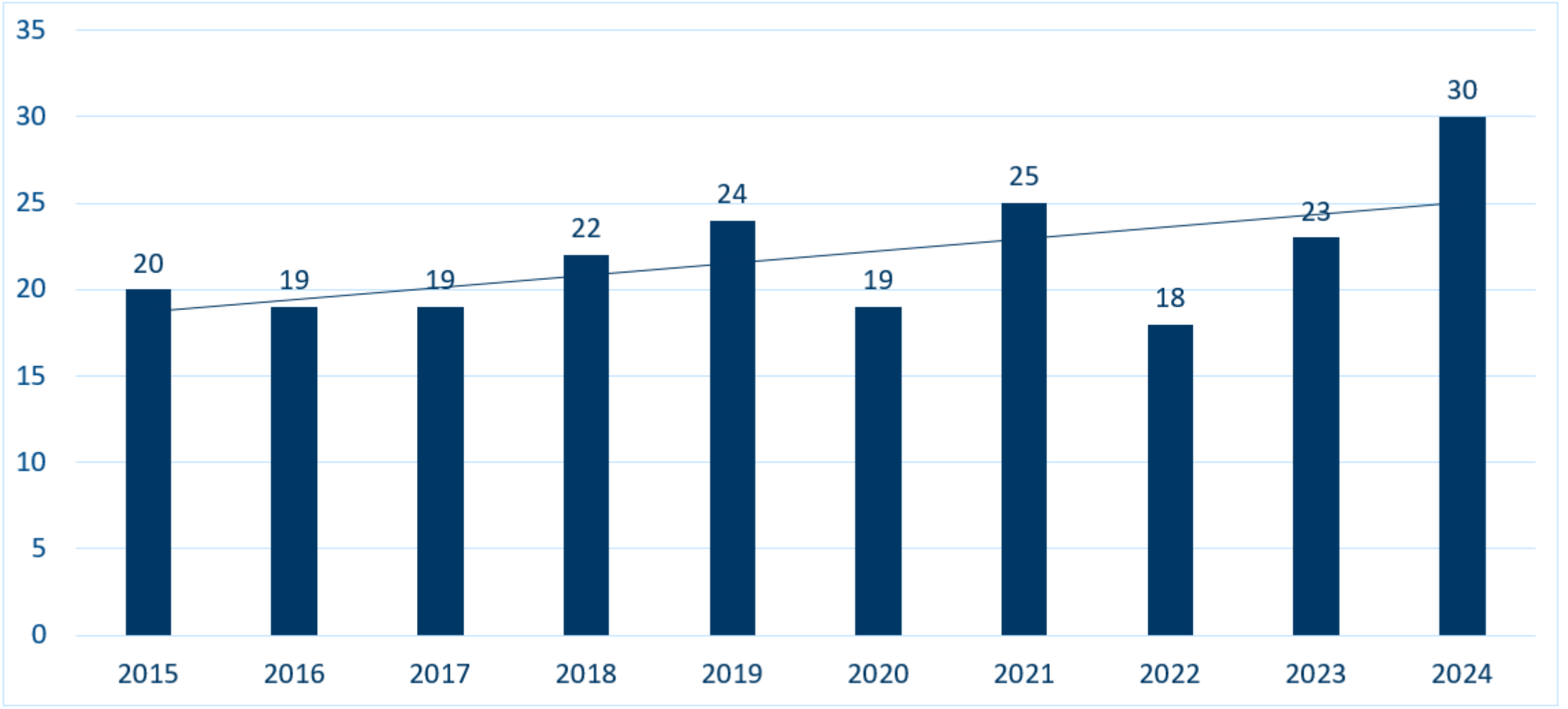


Wrong Body Part Procedure Events Additional Information

- 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 2015-2024



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.

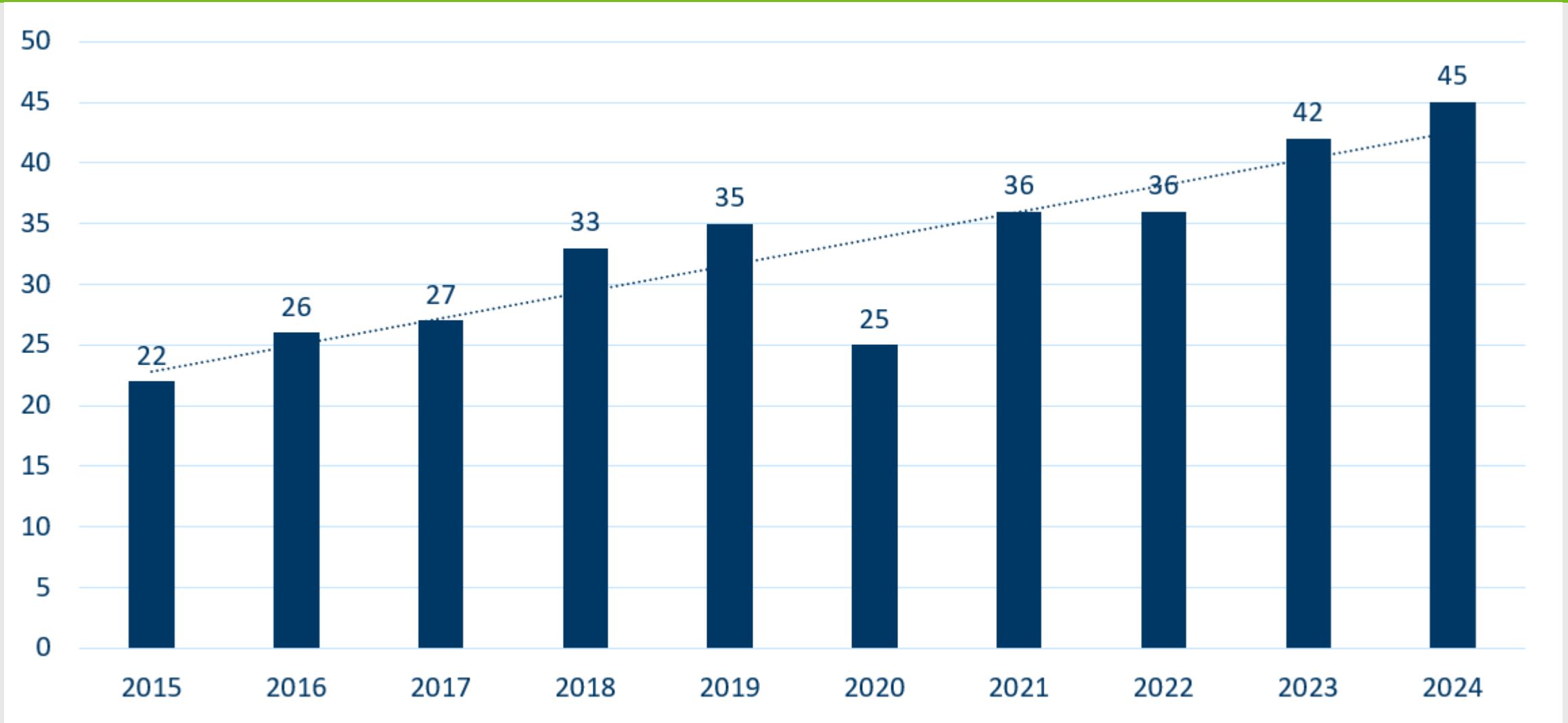
- Most Common types of reported wrong procedure events:
  - Eye procedures (incorrect implant placed)
  - Orthopedics
  - Gynecology

Wrong Body Part/Wrong Procedure

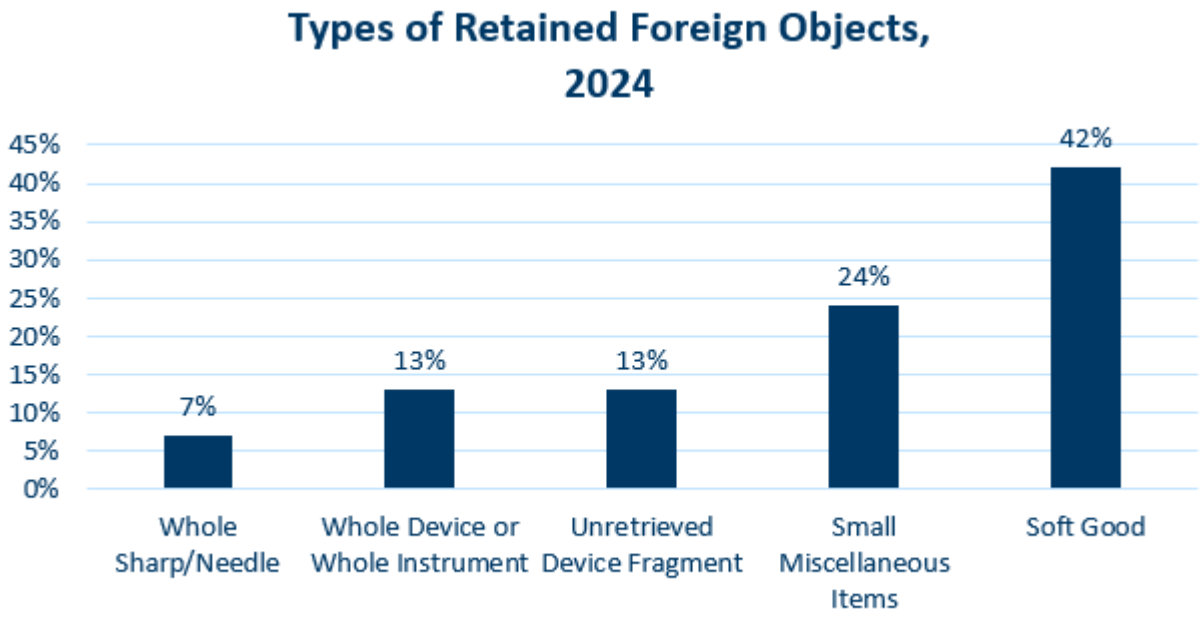
Commonly reported root causes/contributing factors:

- Drift in Time Out rigor
  - Site mark not visualized
  - Laterality not confirmed
  - Lack of proper source documents
- Lack of communication during staff turnover during the procedure
- Procedure not consistent with consent form

Retained Foreign Objects 2015-2024



Retained Foreign Objects Additional Information



Trends/Patterns

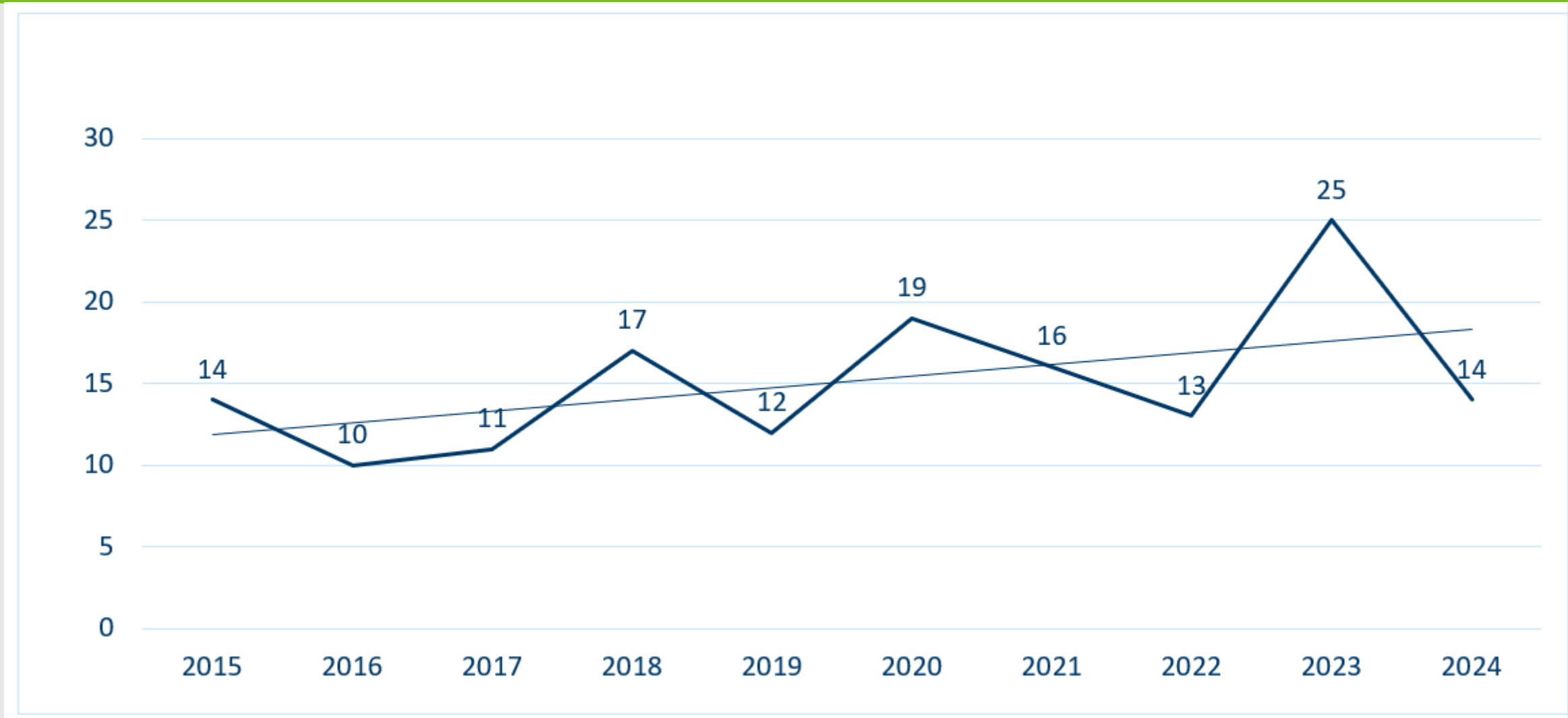
- Procedure Location
  - 49% operating room
  - 19% ambulatory surgery
  - 10% emergency department
- 33% were packed items intended to be removed at a later time, but not removed as intended
- 6% broken items (down from 32% the year prior)

Retained Foreign Objects Additional Information Cont.

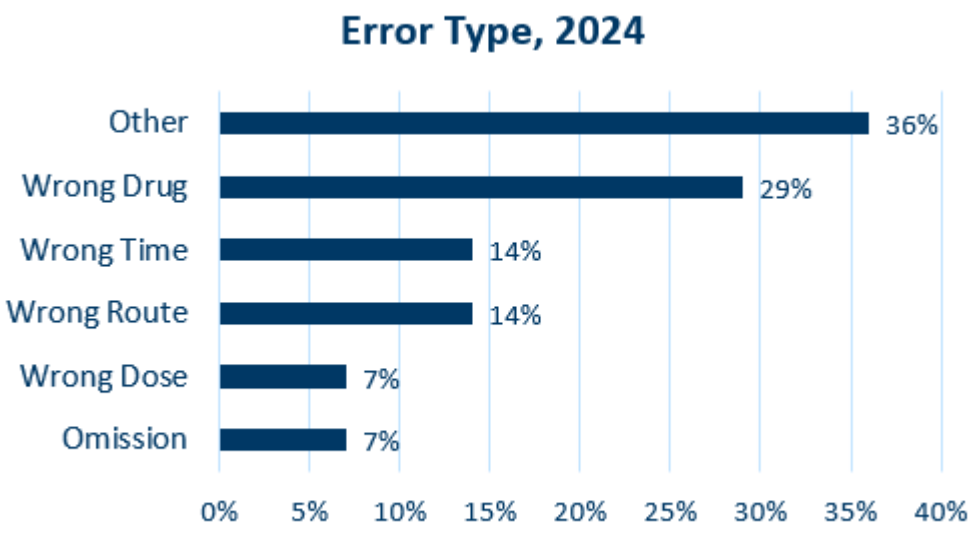
Commonly reported root causes/contributing factors:

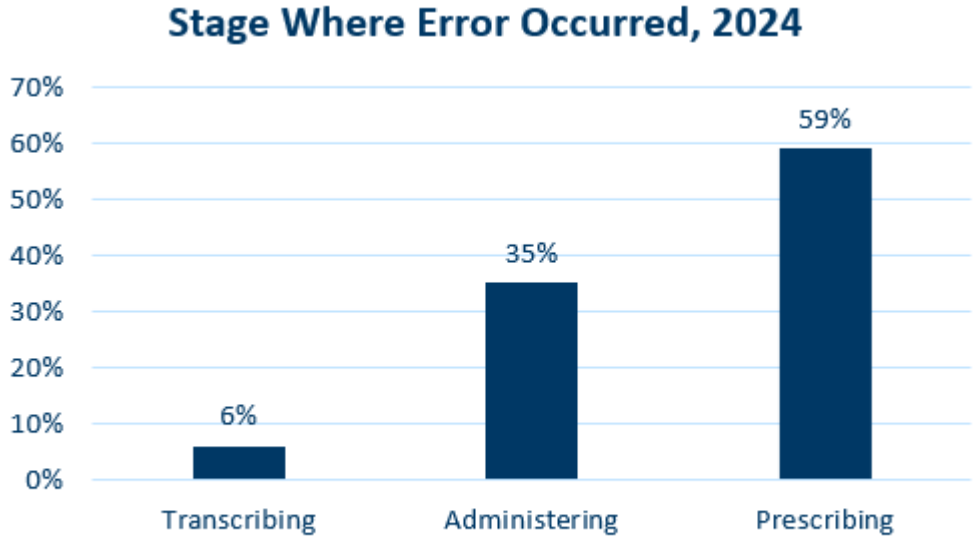
- Drift in rigor for the count of items
- Staff changeover during procedure
- Missing packed items that were intended to be removed after the procedure and before discharge
  - Communication breakdown between staff
  - Missing orders to remove packing or other devices or lack of standard process for writing those orders

Reported Medication Errors 2015-2024



Medication Errors Additional Information





Next Steps

- In the upcoming year, MDH and its partners will:
  - Work with reporting facilities on implementing best practices around surgical events
  - Work with reporting facilities around adherence to best practices for reducing pressure ulcers and falls
  - Work with experts statewide to update the Perinatal Roadmap in 2026
  - MHA will be hosting a two day, in-person conference for hospital and health systems to share and learn about best practices related to quality, safety, and high reliability

Additional Information from the Adverse Health Events Program Available Online

- **Adverse Health Events Homepage**

Adverse Health Events
(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)

- **List of Minnesota's 29 Reportable Events**

Minnesota's 29 Reportable Adverse Health Events
(https://www.health.state.mn.us/facilities/patientsafety/adverseevents/adverseevents.html)