Financial Disclosure

This presentation has no ineligible company content, promotes no ineligible company, and is not supported financially by any ineligible company. I receive no financial remuneration from any ineligible company related to this presentation.

Clinical Risk & Safety Overview

Ogden Surgical – Medical Society
CME Conference 2024

Max Kirschman, MHA

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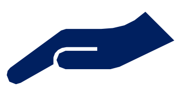
Supporting Teams in Clinical Excellence

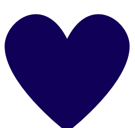
Executive Leaders

VP Chief Quality and Safety Officer
AVP Clinical Excellence Operations

System Led • Locally Deployed • Caring and Learning Together



Clinical Risk & Safety



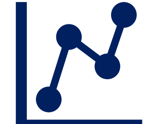
Patient Experience

Quality

Infection Prevention

Clinical Relations

Regulatory Affairs



Clinical Data Management

Physician Advisory/ CDI

Strategic Project Management

Clinical Policies

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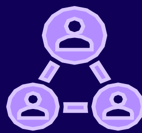
Why

Trust & Psychological Safety

Simplify

System Learning

Efficiency



Harm Levels

LOW HARM	A - No Event/No Near Miss
	B - Did not reach an individual or there was no damage as a result of the event; Near miss
	C - Reached an individual, no harm
	D - Reached an individual, required monitoring or intervention
	E - Temporary harm requiring non-life saving intervention
HIGH HARM	F - Temporary harm requiring higher level of care or prolonged hospitalization
	G - Permanent harm without life sustaining care
	H - Life sustaining intervention required
	I – Individual death

High Harm Event

Triaged and managed by the Clinical Risk & Safety team

High Harm Event

Not a Grievance

Triaged and managed by the Clinical Risk & Safety team

High Harm Event

Grievance

Triaged by Clinical Relations

Co-managed by Clinical Relations & Clinical Risk & Safety team

Low Harm Event

Not a Grievance

Triaged by the Clinical Risk & Safety

Managed by the department manager

Low Harm Event

Grievance

Triaged and managed by the Clinical Relations team

Litigation Event

Received by legal risk team

Co-managed by legal & Clinical Risk & Safety team

Pharmacy Involved with all medication events

Lifecycle of a Safety Event

Reporting → Rapid Assessment → Analysis and Classification → Action Planning → Closing the Loop

Life of a Safety Event

You cannot fix what you do not know is broken…

Event Reported

Reporting

- Event reported into event system
- Routed to appropriate team for follow up

Rapid Assessment

- Sentinel/reportable events to REI
- Non-reportable high-harm events are sent for care review
- All grievances events are sent for care review

Rapid Assessment

Rapid Event Investigation

(REI)

- Reportable/sentinel events
- Caring & learning response
- Safety Pause & Debrief
- Safety Event Notification team
- REI meeting

Harm Event Assessment & Learning

HEAL

Analysis & Classification

- High harm or serious precursor events not meeting reportable criteria
- Multidisciplinary service line teams
- Action planning in real-time or cause analysis team identified
- Classify preventable harm

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Cause Analysis

Analysis & Classification

- Facilitated by Clinical Risk Safety Team
- Lead by Executive Sponsor(s)
- Identify and prioritize all causes

- Accountability dependent on event type
- Both remedial and strong actions are needed

Corrective Action Planning

High-harm/Sentinel event action plans:

- Local & system implementation
- Strength, implementation, & sustainability measured and documented
- Critical for regulatory readiness

Action Planning

Share Learning

- With involved caregivers
- With affected patients
- System Lessons Learned

Closing the Loop

Rapid Event Investigation (REI)

A multidisciplinary process initiated immediately after a sentinel event centered in **CARING** for involved caregivers and creating space for systematic **LEARNING**

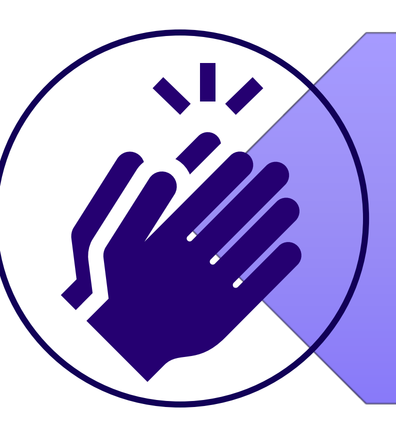
Key Outcomes

- Ensure the care team is safe to continue caring for patients.
- Early support & communication with the patient/family.
- Support for involved caregivers including EAP & Peer Support.
- Identify learning opportunities & coordinate next steps including:
  - ✓ immediate mitigation needs
  - ✓ regulatory readiness
  - ✓ cause analysis coordination
  - ✓ executive sponsor identification

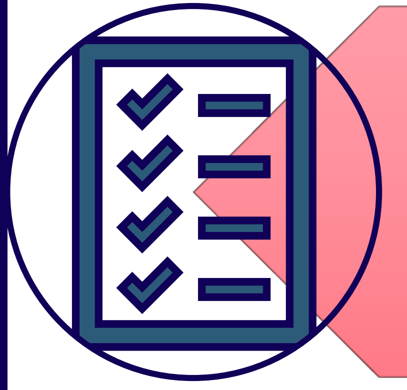
Safety Pause
Caring and Learning Together

The Safety Pause is an effective way for teams to respond when things don't go the way we intended. A pause can be helpful after any difficult event, for example after the passing of a patient, a caregiver injury, a medication error, or an emotional encounter with an upset family member.

Asks



Empower & partner with local leaders to act on medication events



Document your event review timely in the event management system

Model Safety Language

"I have a concern..."

"Let's escalate this to our leader"

"Is everyone comfortable proceeding?"

"Let me ask a clarifying question..."

I have a concern...
Is everyone comfortable proceeding?
Speak Up

How can I show up for you today?
How do you elevate safety where you work?

How can I show up for you today?
Speak Up
How do you elevate safety where you work?

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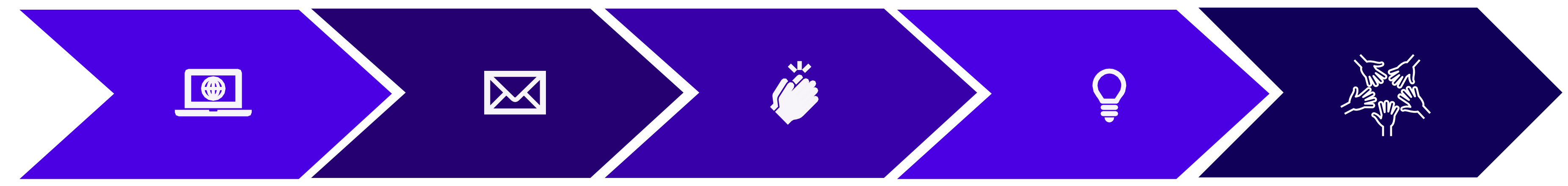
Good Catch Process



Caregiver enters good catch in SafetyNet

Leader receives email notification from SafetyNet

Leader celebrates caregiver(s)

Good catch is escalated for further learning and/or team begins process improvement, if applicable

Senior Leadership receives weekly report for additional celebrations

Patient Safety: Safety Event and Reporting Trend

Canyons, Desert Regions

SSER

1.20
1.00
0.80
0.60
0.40
0.20
0.00

8000
7000
6000
5000
4000
3000
2000
1000
0

Events Reported

Jan-21 Apr-21 Jul-21 Oct-21 Jan-22 Apr-22 Jul-22 Oct-22 Jan-23 Apr-23 Jul-23 Oct-23 Jan-24

Preventable Significant Harm Rate (Previously SSER)
Events reported

CONFIDENTIAL: This information is for an Intermountain Healthcare Peer or Care Review Committee to evaluate and improve health care. See Utah Code 26-25-1, et seq., U.R.C.P. 26(b)(1), or Idaho Code 39-1392, et seq.

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We will chase perfection,
and we will chase it relentlessly,
knowing all the while we can never
attain it. But along the way, we
shall *catch excellence.*
-Vince Lombardi