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OGDEN SURGICAL-MEDICAL SOCIETY
CME Excellence Since 1946

Intermountain Health

Clinical Risk & Safety Overview

Ogden Surgical – Medical Society CME Conference 2024

Max Kirschman, MHA

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

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

Event Management

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

Life of a Safety Event

You cannot fix what you do not know is broken…

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Reporting

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

Event Reported

- 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

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Rapid Assessment

Rapid Event Investigation

(REI)

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

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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

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

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- 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

Share Learning

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

Closing the Loop

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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**

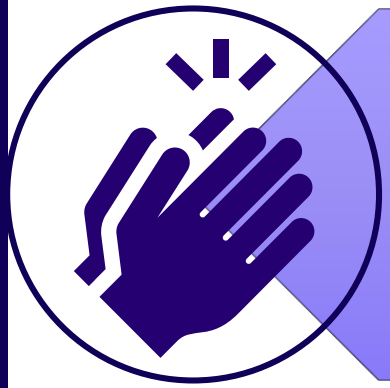
Key Outcomes

- 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

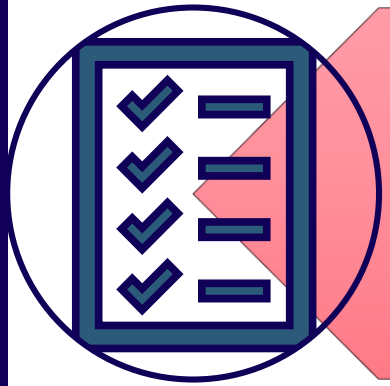
Safety Pause
Caring and Learning Together

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

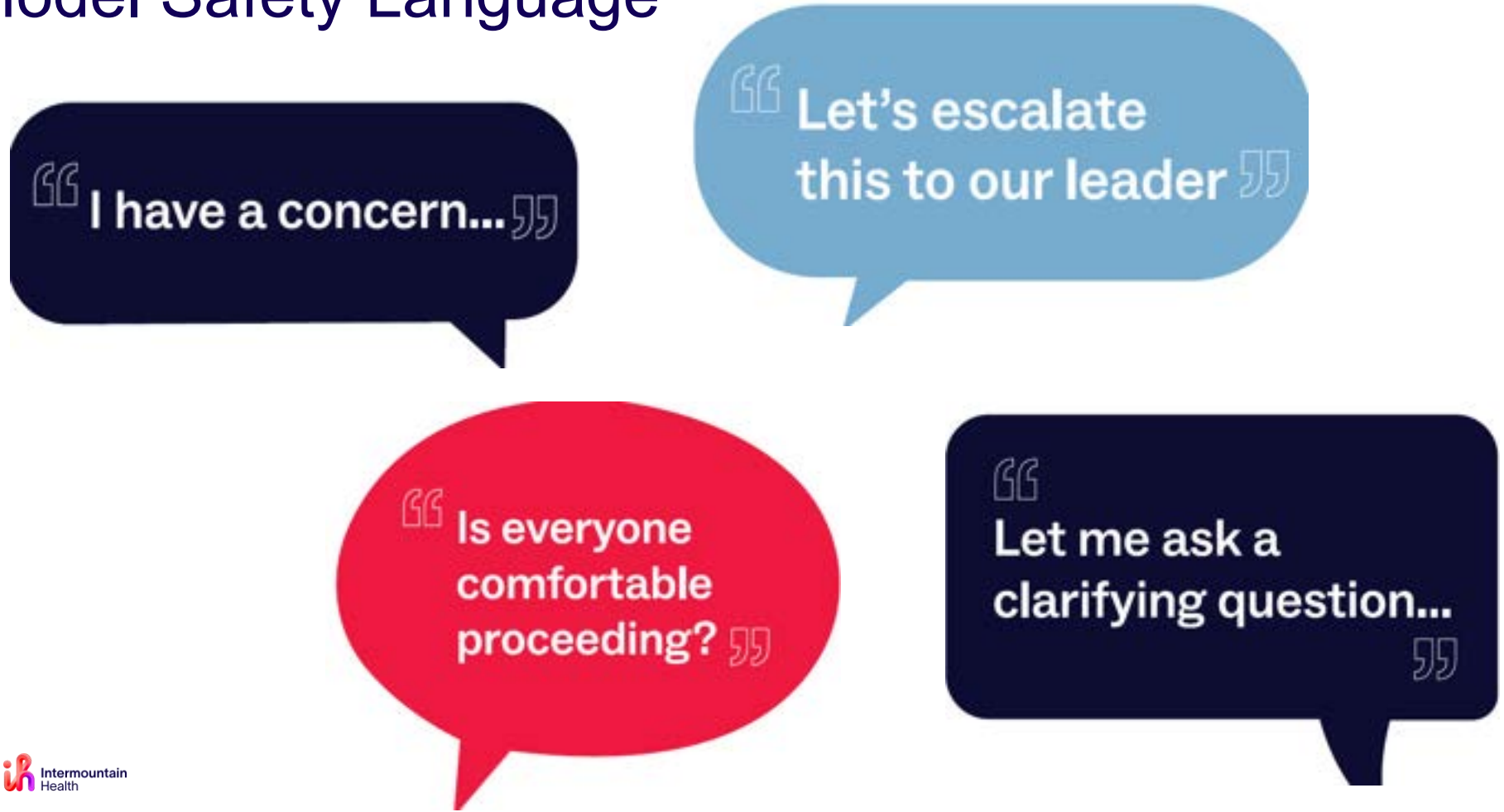


Empower & partner with local leaders to act on medication events



Document your event review timely in the event management system

Model Safety Language



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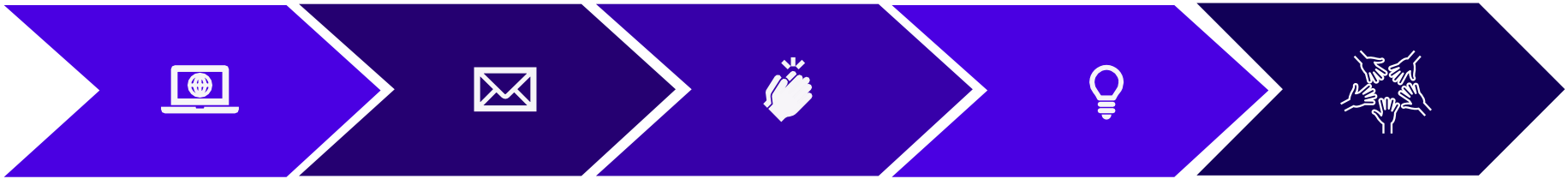
Good Catch Process



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

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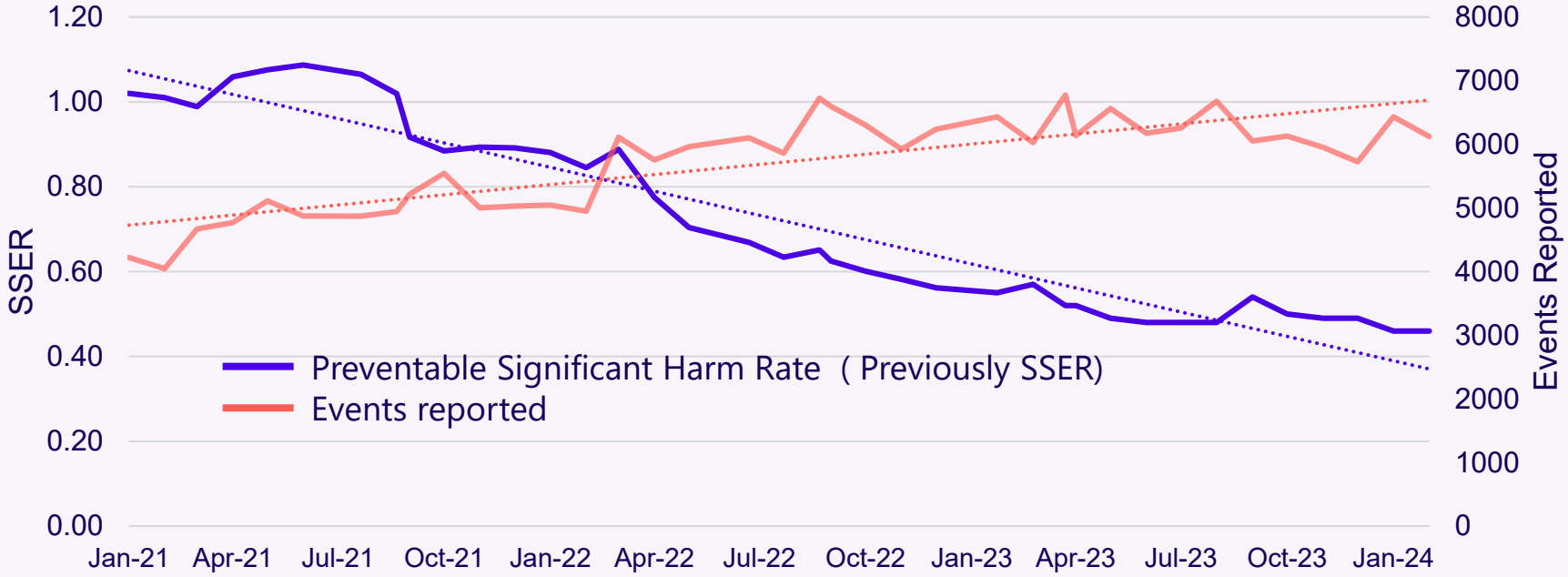
Patient Safety: Safety Event and Reporting Trend

Canyons, Desert Regions




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