
RISK UNDER ONE ROOF
2024 KOnnect
Where the magic happens

Where the magic happens

2024 KOnnect

Sentinel Event Management: Practical Tech Solutions

How a hospital system utilized the cause analysis module to improve upon patient safety

Juliana Aadland MSN, RN, CPHQ

Allina Health

Objectives

- Gain a clear understanding of how the **Riskonnect platform supports a health systems cause analysis** (ACA, RCA, and CCA) program.
- **Learn the key features** within the Riskonnect cause analysis module relevant to a successful cause analysis program
- Recognize **the importance of transparency** in the platform and how it contributes to **organizational learning and safety improvement**.
- Be able to **use the platform effectively** to enhance safety culture and outcomes within their own organizations.

Allina Health System

Our Mission: to serve our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care.

Our network of care locations includes:

- 12 hospital campuses
- 20 same-day and urgent care centers
- 60+ primary care clinics
- 100+ specialty care sites throughout the communities we serve including:
  - retail pharmacy
  - mental health and addiction
  - emergency medical services
  - same-day surgery centers
  - expert specialty care for cancer, heart, neurology, orthopedics, rehabilitation and more

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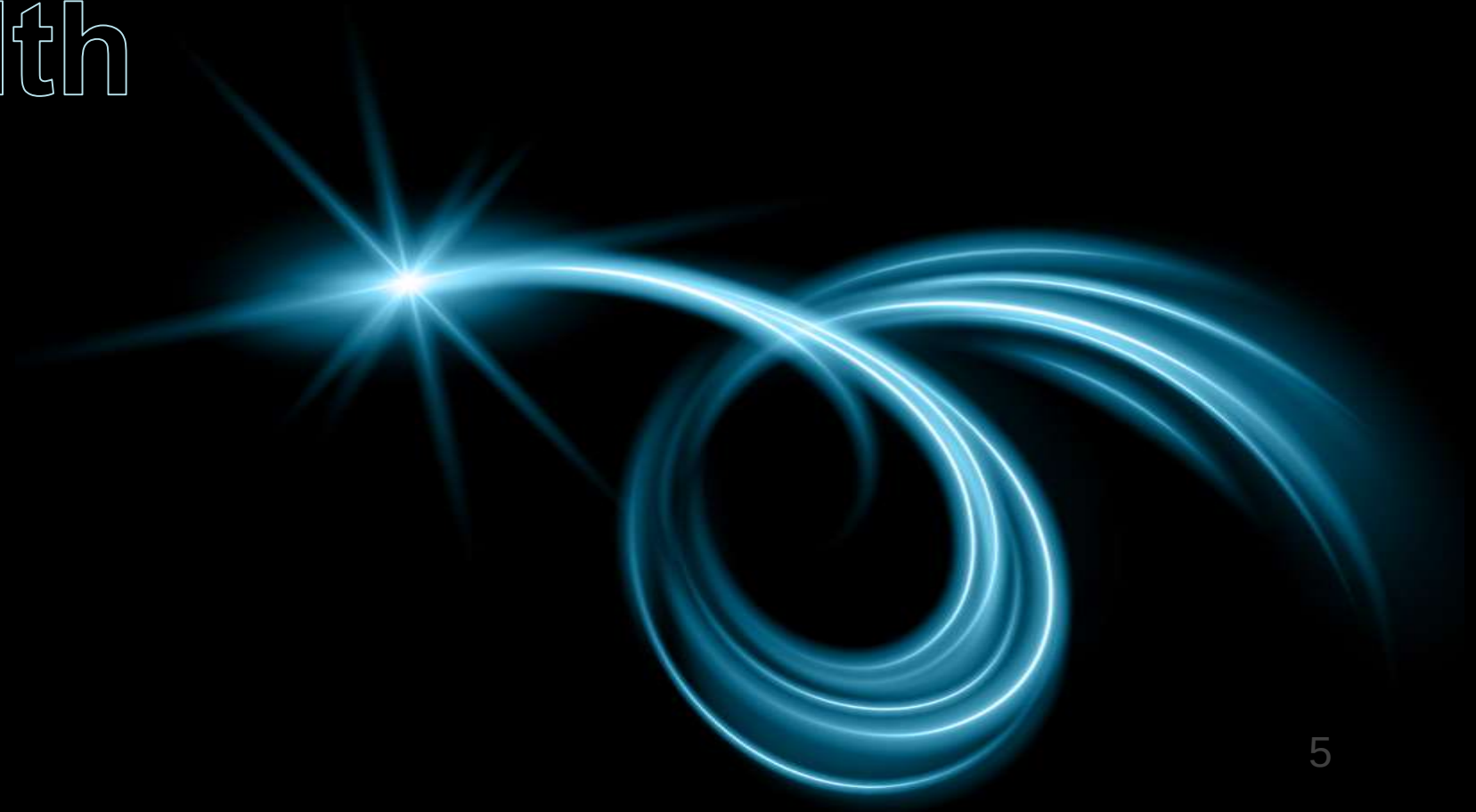
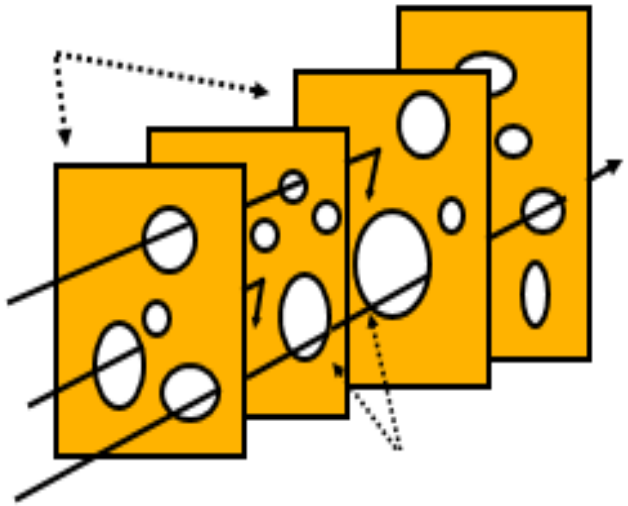
High Performing Cause Analysis Program



Detecting, Preventing, & Correcting

Find holes by
DETECTION

HRO Behaviors & Skills



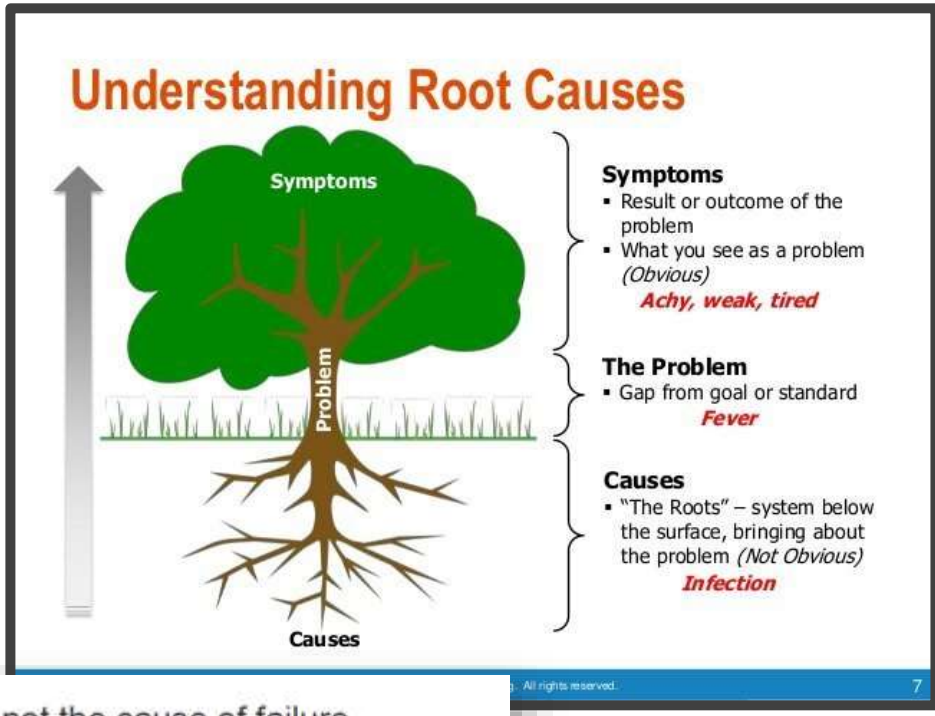
Reduce the size or eliminate the holes by
CORRECTION

Cause Analysis Improvement

Reduce Initiating Actions by
PREVENTION

High Performing Cause Analysis Program

- Identify the root solution(s).
  - What happened
  - Why did it happen
  - What do you do to prevent it from happening again
- Action plans that prevent recurrence and build accountability.
- Promote continuous learning, sharing lessons learned.
- Reduction in serious safety events.

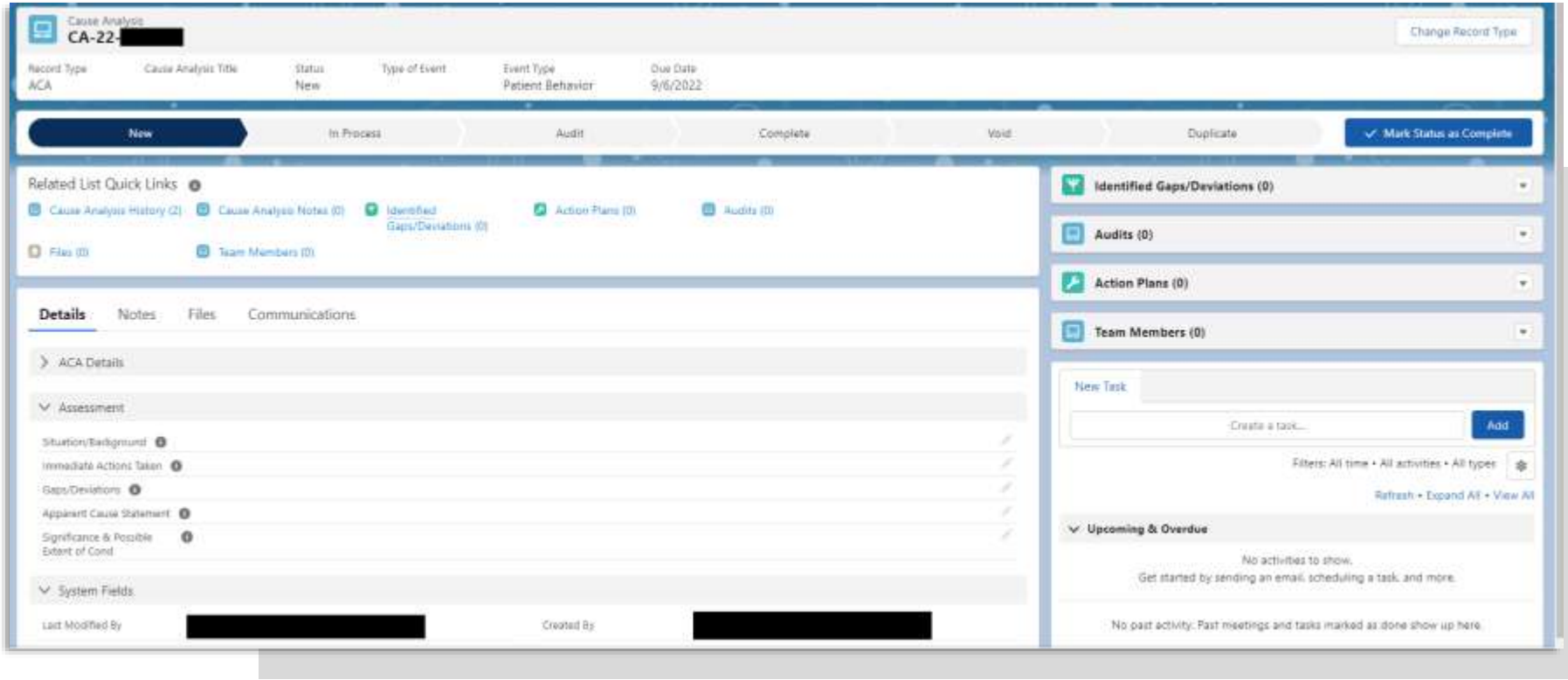


Human error is not the cause of failure,
but a *symptom of failure*

Human error – by any other name or by any other human – should be the *starting point* of our investigations, not the conclusion

Key Features Relevant to a Successful Cause Analysis Program

- Streamlined Process
- Deeper Answers
- Driving Strategy



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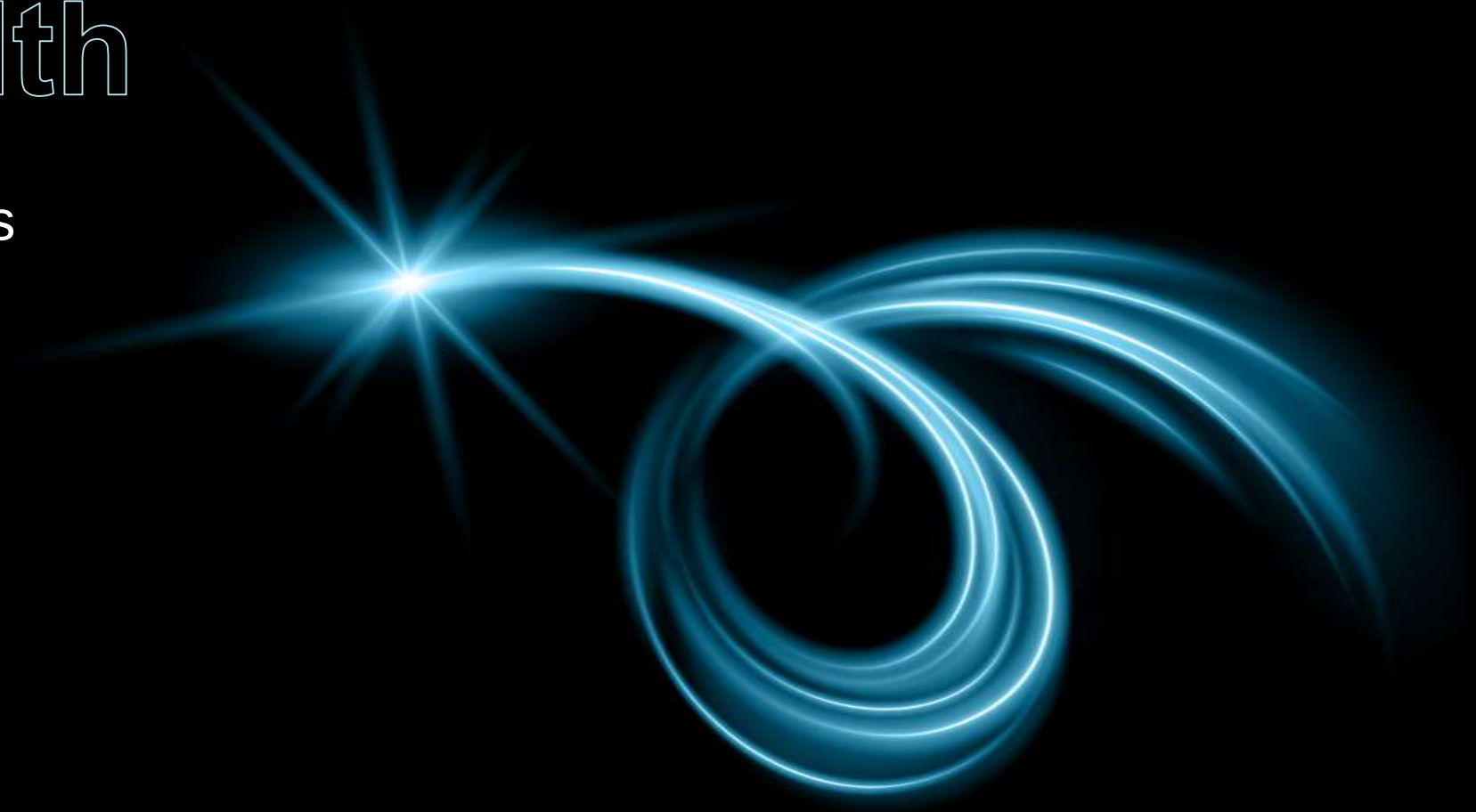
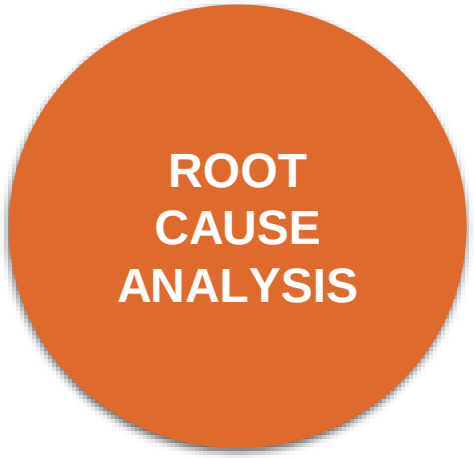
Integrating into Operations



High Performing Cause Analysis Program



Safety Advisor

A structured problem-solving technique that results in one or more corrective actions to prevent recurrence of an event.

Leaders

A limited investigation of an event that is performed instead of RCA for less-complex safety events.

Safety Advisor

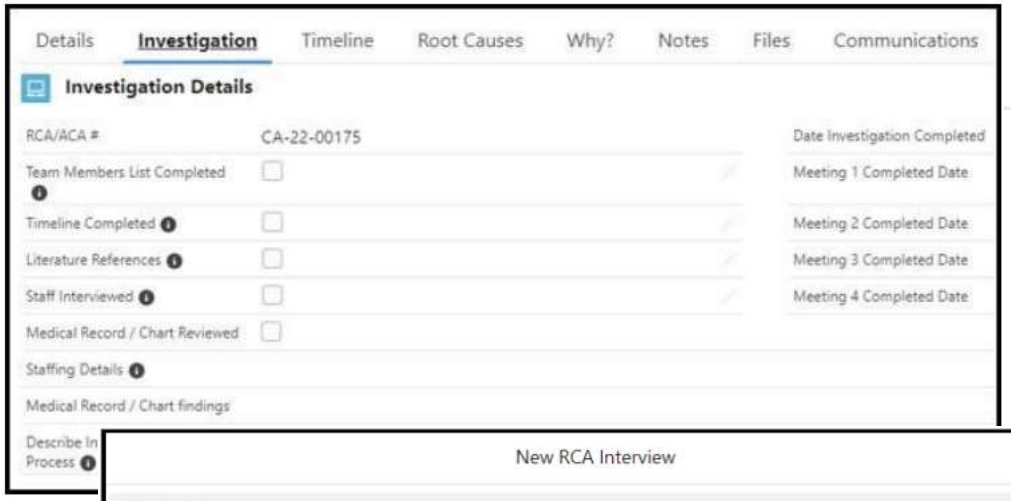
A method to periodically examine the common characteristics and causes of many previous events.

The RCA for Safety Advisors

1. **Fact Finding/Investigation**
2. **Identify Causes**
3. **Action Planning**

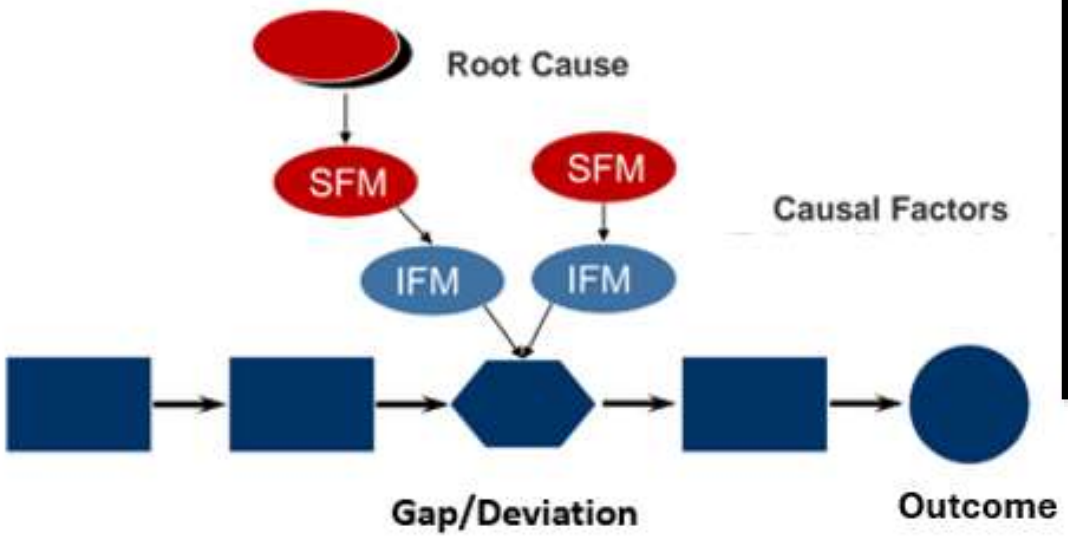
The RCA for Safety Advisors

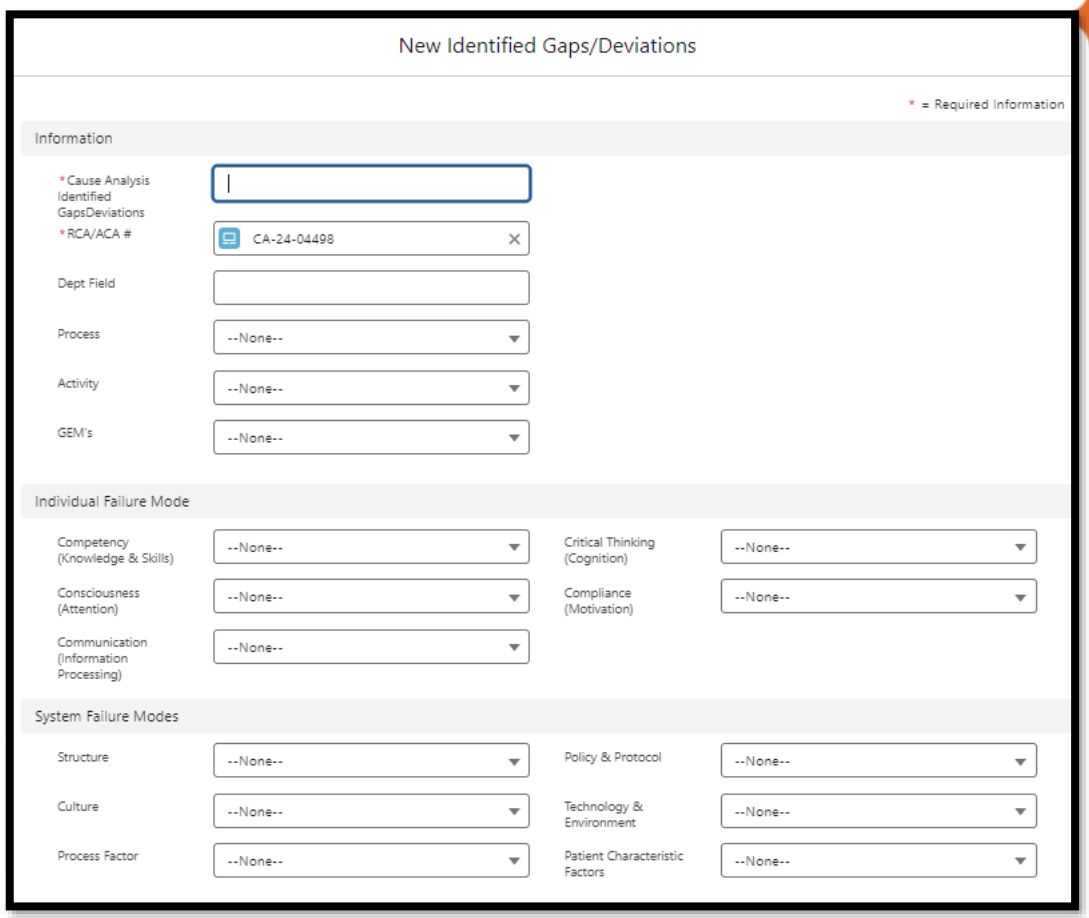
- Fact Finding/Investigation
  - Identify root cause team
  - Sequence of events
  - Coordinate interviews/data gathering



The RCA for Safety Advisors

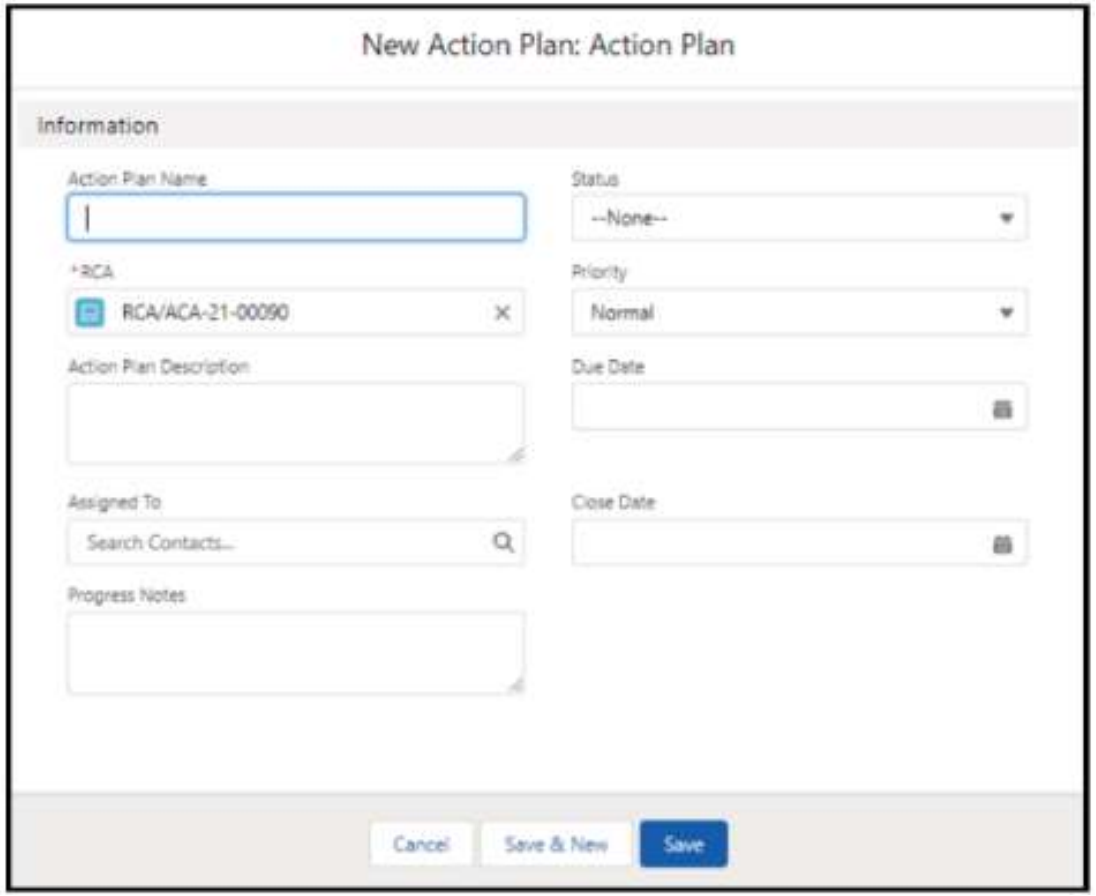
- Identify Causes
  - Agree on facts & causes
  - Build consensus for root causes





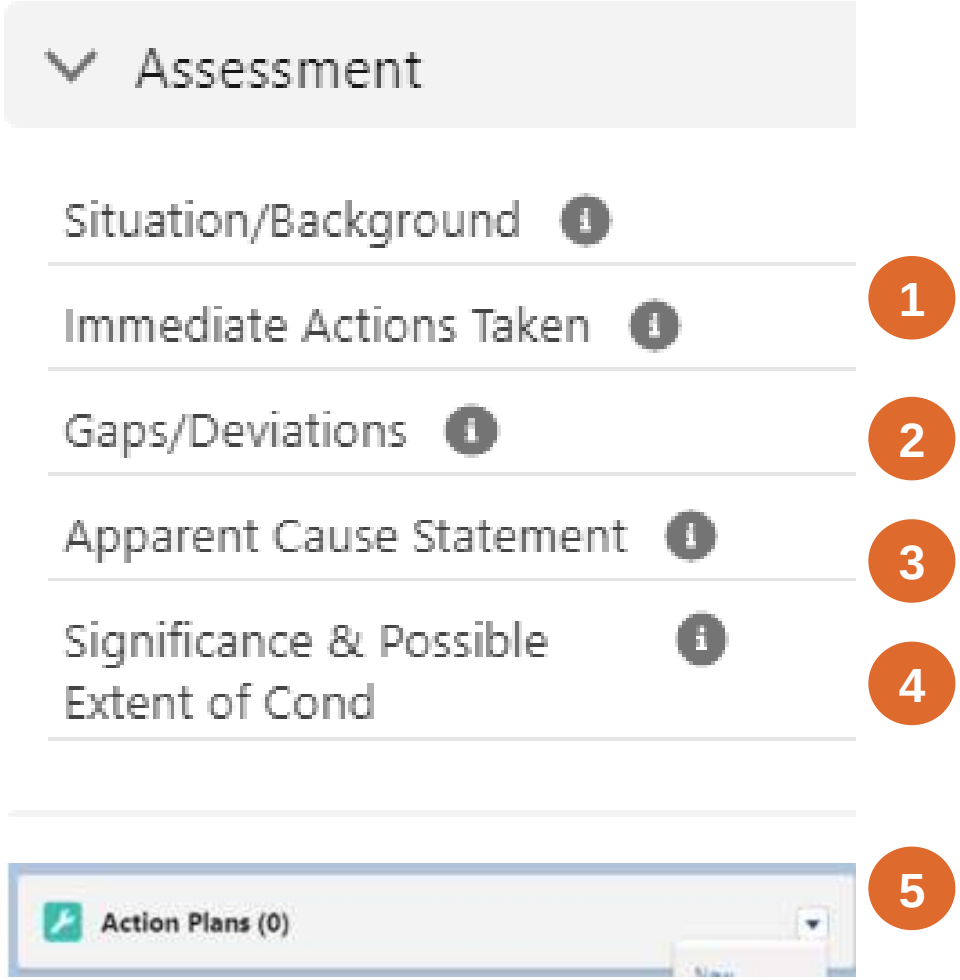
The RCA for Safety Advisors

- Action Planning
  - Consensus on root causes
  - Finalize action plan to prevent recurrence
  - Cascade learnings



The ACA for Leaders

1. Briefly investigate the event
2. Identify the gaps or deviations



3. Develop an apparent cause statement
4. Describe significance of the occurrence
5. Identify Action Plan for Improvement

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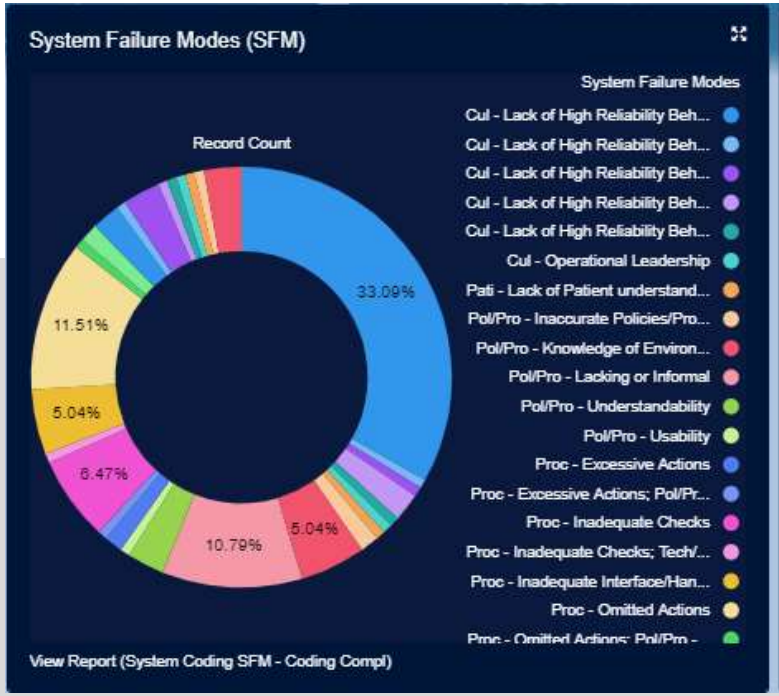
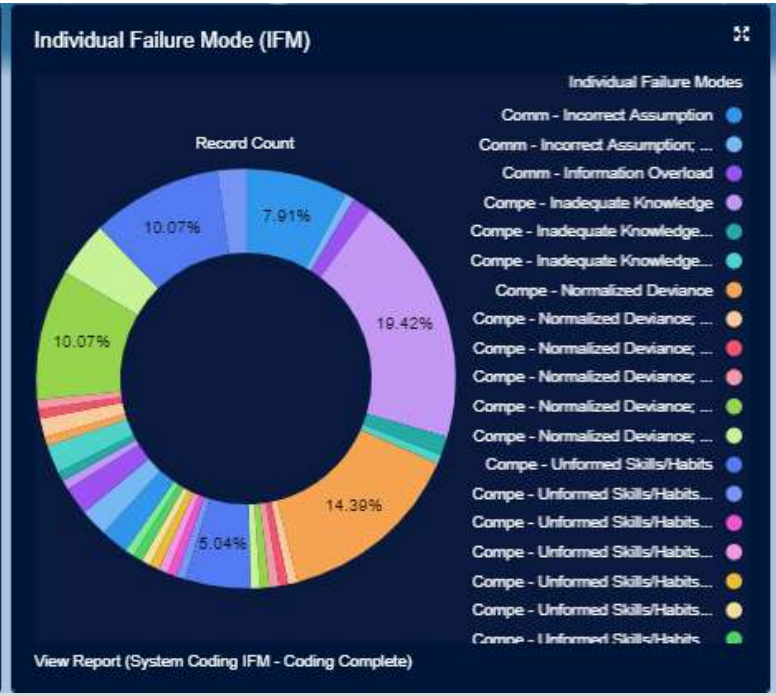
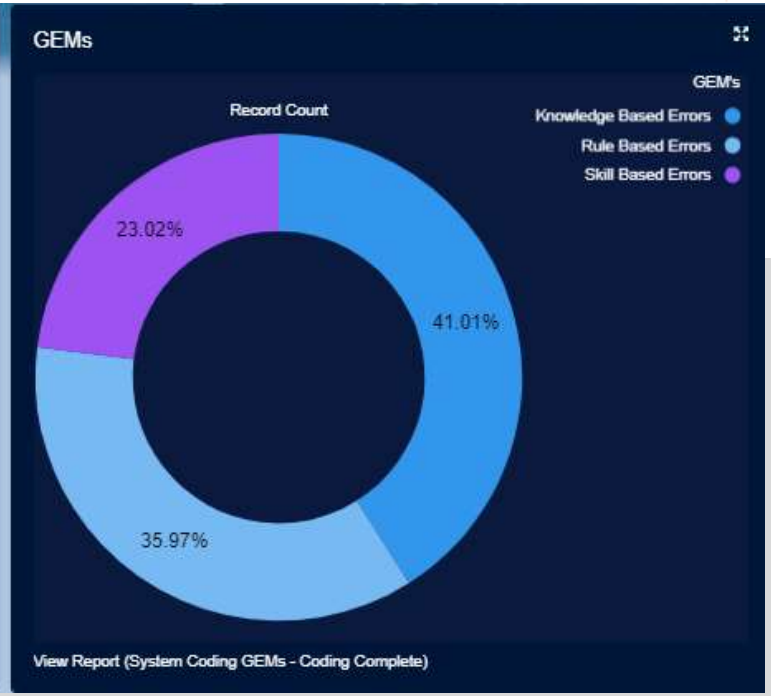
Organizational Learning & Enhancing Safety Culture

Riskonnect Automating the Common Cause Analysis







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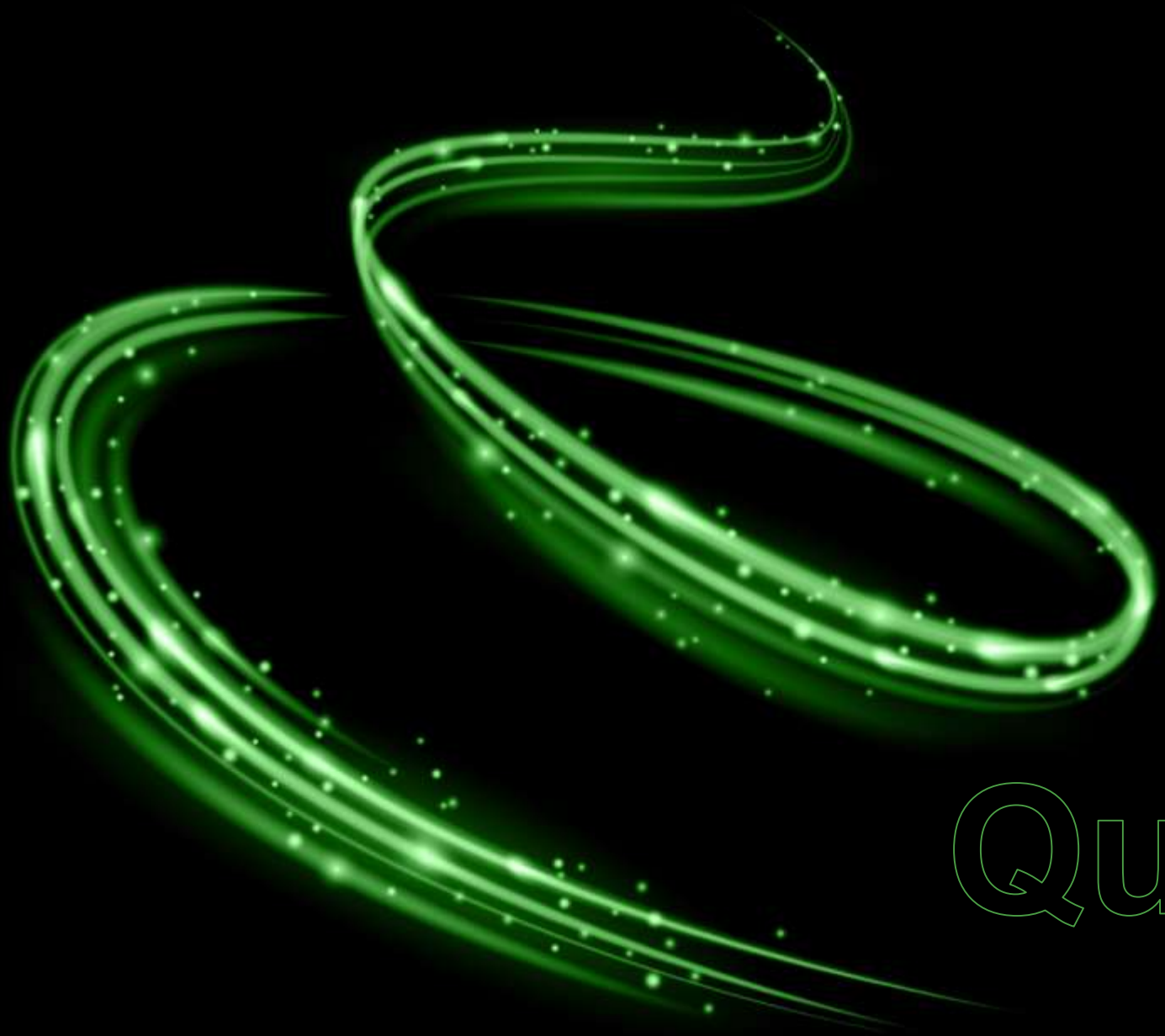
Organizational Learning & Sharing Learnings from Events

- Leaders' security access to allow all leaders to see any ACA/RCA.
- What's next?
  - Utilizing Riskonnect cause analysis module to support story telling
  - Integrate Riskonnect cause analysis information into daily safety huddles.

"It is necessary for us to learn from others' mistakes. You will not live long enough to make them all yourself."

Admiral Hyman G. Rickover



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Questions?


Thank You!
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CONNECT WITH ME.

Juliana Aadland MS, RN, CPHQ

e: juliana.aadland@allina.com

w: allinahealth.org/

in juliana-aadland-52a556b0/

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