

RISK UNDER
ONE **ROOF**

2024 **Kōnnect**

Where the
magic
happens



Where the
magic
happens

2024 **Kōnnect**

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

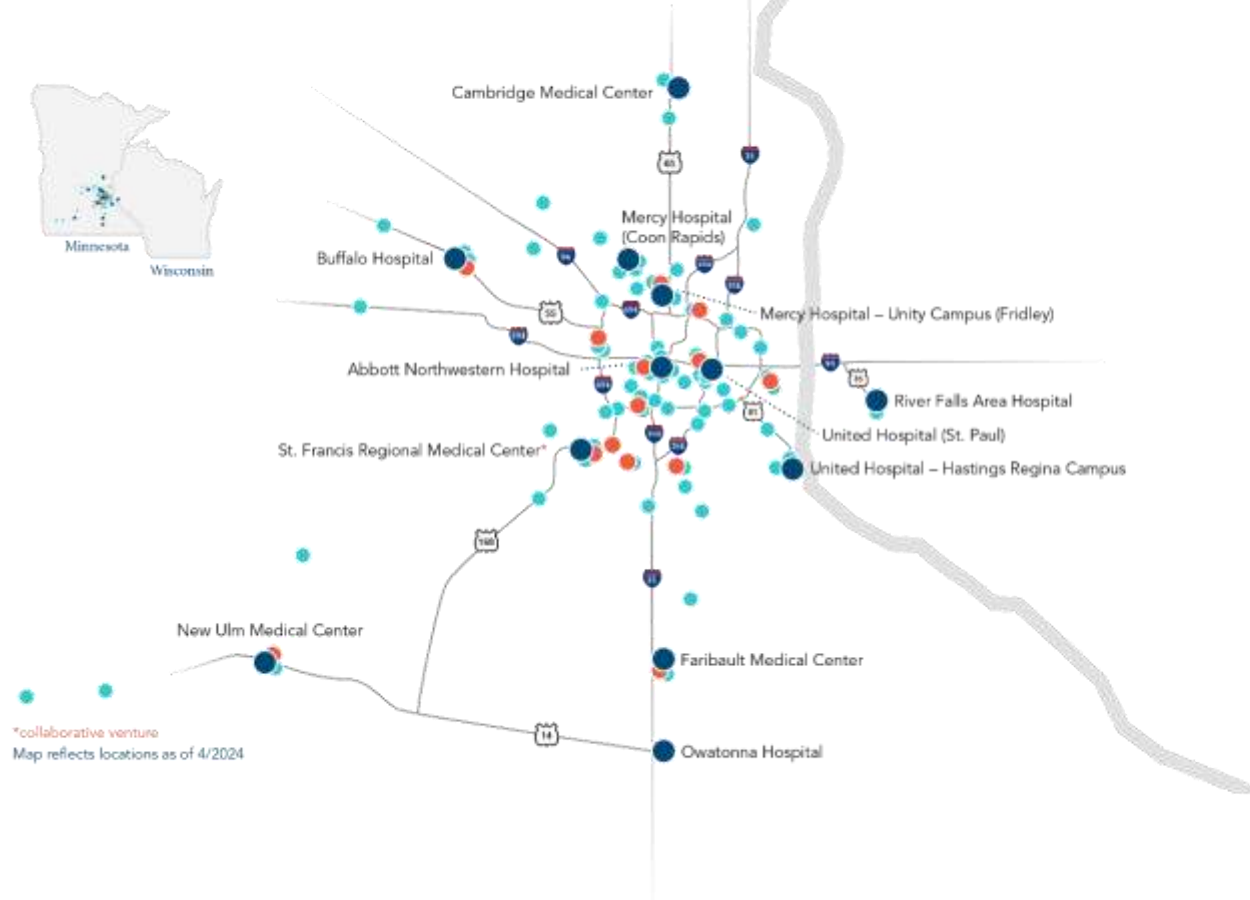
Objectives

- Gain a clear understanding of how the **Riskconnect platform supports a health systems cause analysis** (ACA, RCA, and CCA) program.
- **Learn the key features** within the Riskconnect 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.

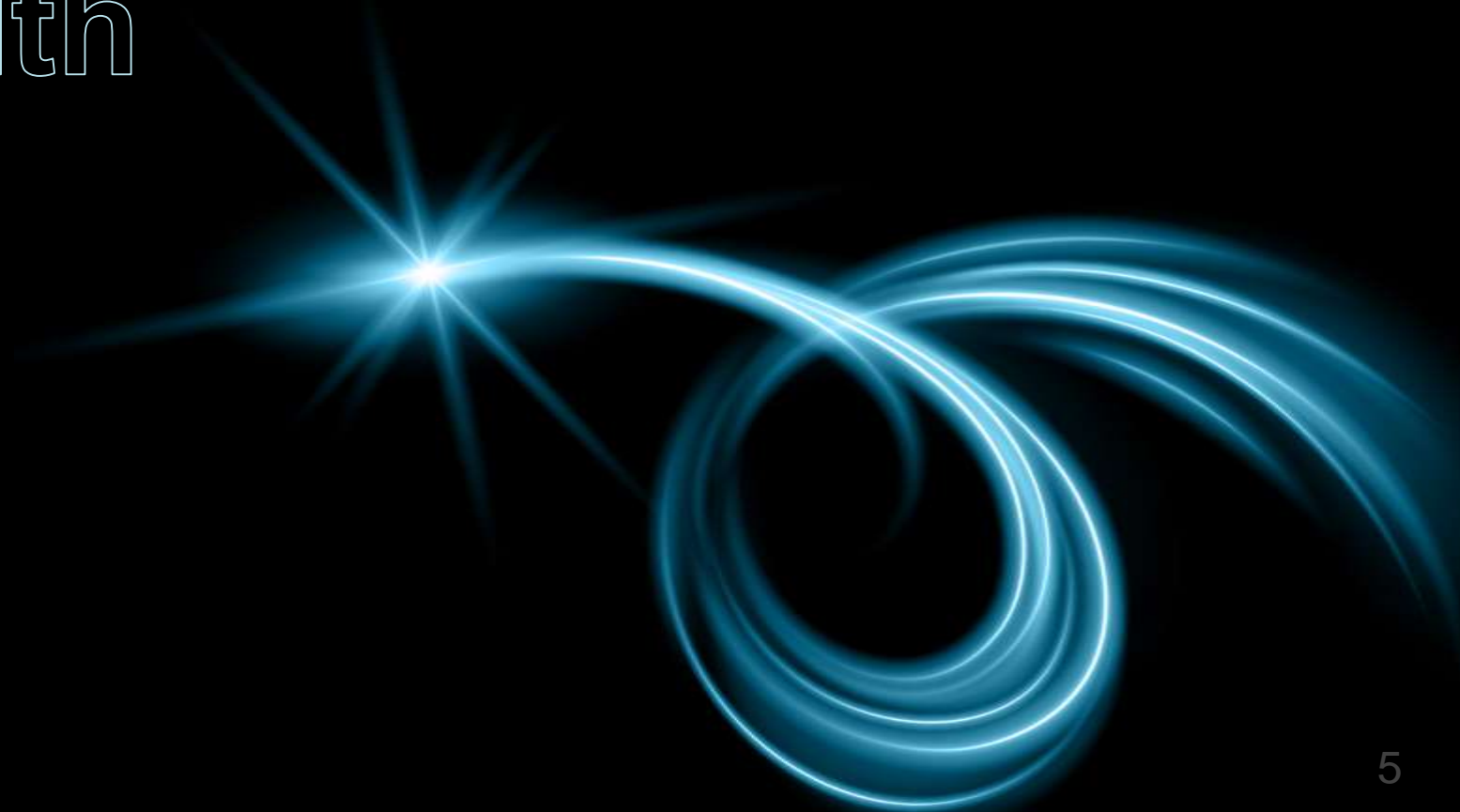


Our network of care locations includes:

- 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



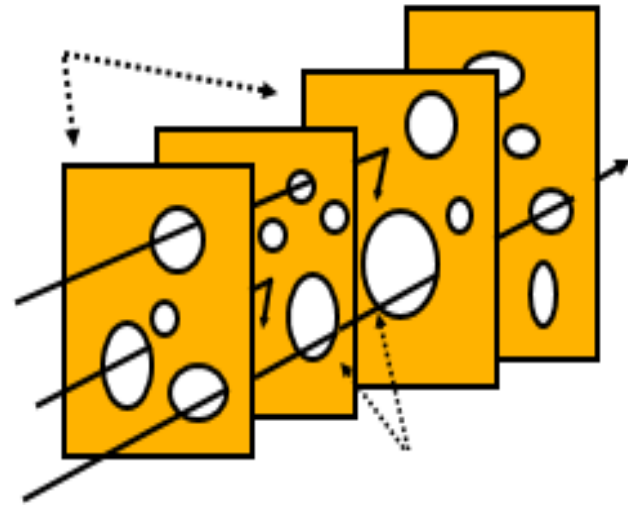
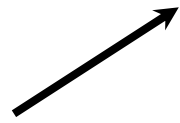
Detecting, Preventing, & Correcting



Find holes by
DETECTION



Reduce Initiating
Actions by
PREVENTION



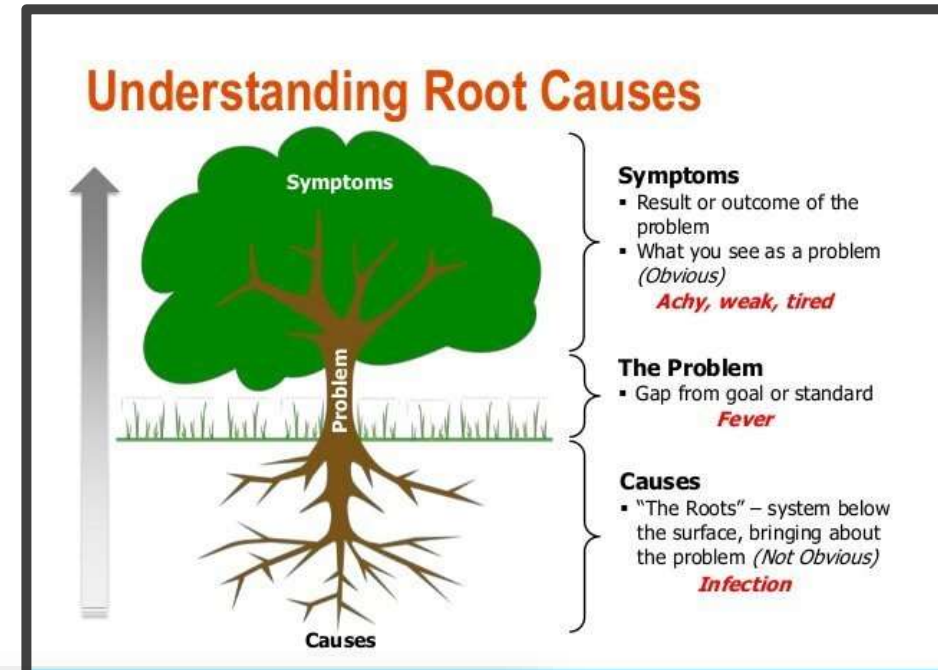
Reduce the size or
eliminate the holes by
CORRECTION



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

All rights reserved.

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Key Features Relevant to a Successful Cause Analysis Program

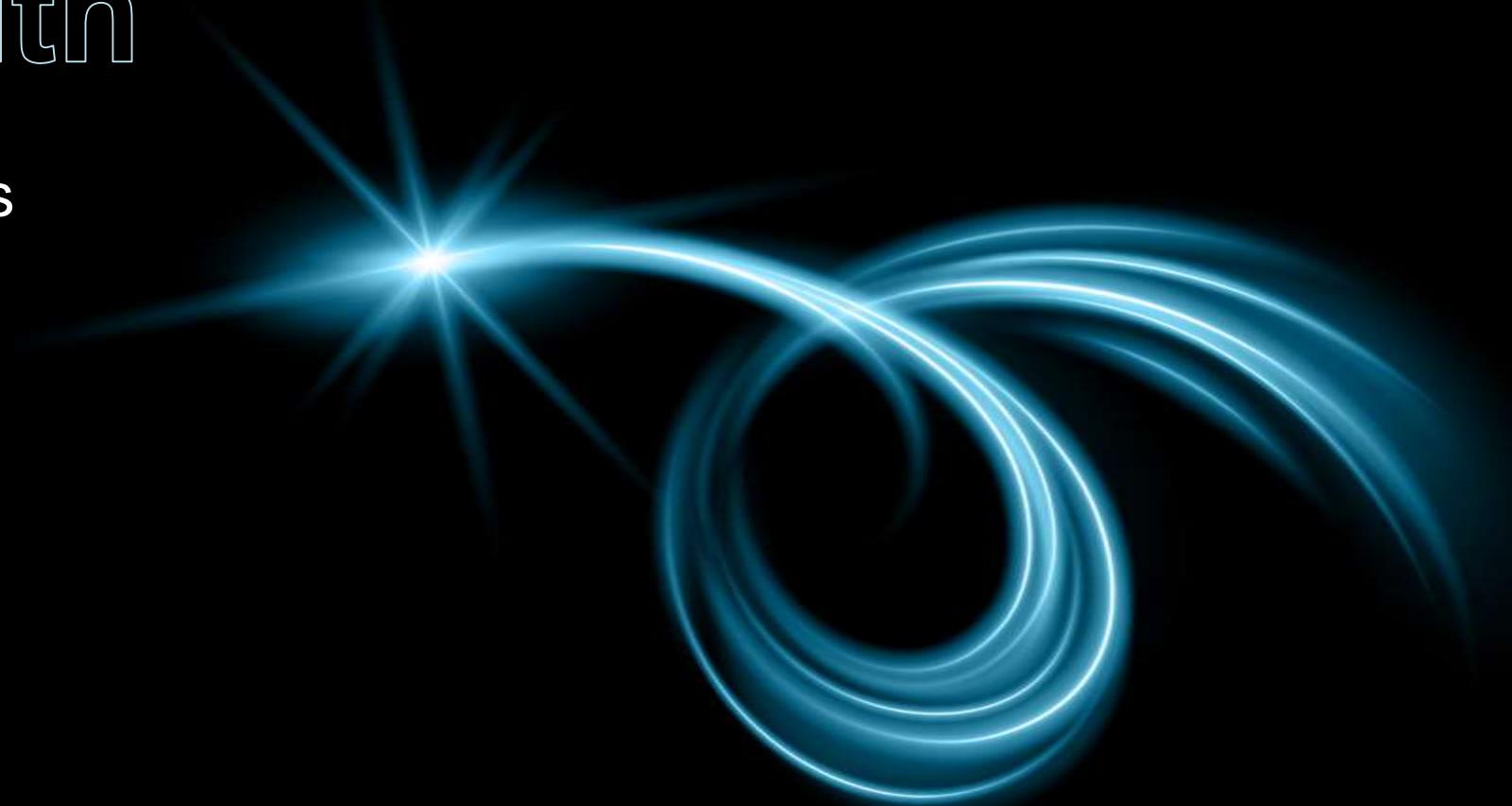


- Streamlined Process
- Deeper Answers
- Driving Strategy

A screenshot of a web-based Cause Analysis (CA) software interface. The interface is titled "Cause Analysis CA-22-XXXX" and shows a record type of "ACA". It features a navigation bar with buttons for "New", "In Process", "Audit", "Complete", "Void", "Duplicate", and "Mark Status as Complete". Below the navigation bar, there are "Related List Quick Links" for "Cause Analysis History (2)", "Cause Analysis Notes (0)", "Identified Gaps/Deviations (0)", "Action Plans (0)", "Audits (0)", "Files (0)", and "Team Members (0)". The main content area is divided into "Details", "Notes", "Files", and "Communications" tabs. The "Details" tab is active, showing sections for "ACA Details", "Assessment", "Situation/Background", "Immediate Actions Taken", "Gaps/Deviations", "Apparent Cause Statement", "Significance & Possible Extent of Cond", and "System Fields". The "System Fields" section shows "Last Modified By" and "Created By" with redacted names. On the right side, there are several summary cards for "Identified Gaps/Deviations (0)", "Audits (0)", "Action Plans (0)", and "Team Members (0)". Below these is a "New Task" section with a "Create a task..." input field and an "Add" button. At the bottom right, there is an "Upcoming & Overdue" section with a message: "No activities to show. Get started by sending an email, scheduling a task, and more. No past activity. Past meetings and tasks marked as done show up here."

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Integrating into Operations



High Performing Cause Analysis Program



ROOT CAUSE ANALYSIS

Safety Advisor

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

APPARENT CAUSE ANALYSIS

Leaders

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

COMMON CAUSE ANALYSIS

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



| Task | Completion Status | Completion Date |
|---------------------------------|--------------------------|------------------------------|
| RCA/ACA # | CA-22-00175 | Date Investigation Completed |
| Team Members List Completed | <input type="checkbox"/> | Meeting 1 Completed Date |
| Timeline Completed | <input type="checkbox"/> | Meeting 2 Completed Date |
| Literature References | <input type="checkbox"/> | Meeting 3 Completed Date |
| Staff Interviewed | <input type="checkbox"/> | Meeting 4 Completed Date |
| Medical Record / Chart Reviewed | <input type="checkbox"/> | |
| Staffing Details | | |
| Medical Record / Chart findings | | |
| Describe In Process | | |

Information

Contact interviewed:

Root Cause Analysis:

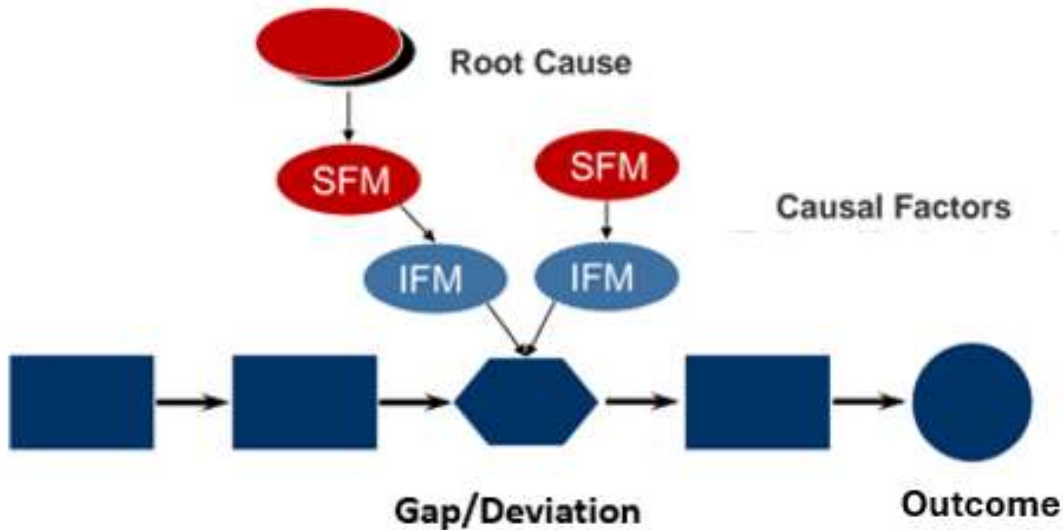
Interview Notes

Rich text editor toolbar: Salesforce Sans, 12, bold, italic, underline, link, unlink, list, list, link, unlink, undo, redo, print.



The RCA for Safety Advisors

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



New Identified Gaps/Deviations

* = Required Information

Information

* Cause Analysis Identified Gaps/Deviations

* RCA/ACA # CA-24-04498

Dept Field

Process --None--

Activity --None--

GEM's --None--

Individual Failure Mode

Competency (Knowledge & Skills) --None--

Critical Thinking (Cognition) --None--

Consciousness (Attention) --None--

Compliance (Motivation) --None--

Communication (Information Processing) --None--

System Failure Modes

Structure --None--

Policy & Protocol --None--

Culture --None--

Technology & Environment --None--

Process Factor --None--

Patient Characteristic Factors --None--

The RCA for Safety Advisors



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

The screenshot shows a web-based form titled "New Action Plan: Action Plan". The form is organized into several sections:

- Information:** This section contains the following fields:
 - Action Plan Name:** A text input field with a vertical cursor.
 - Status:** A dropdown menu currently showing "--None--".
 - Priority:** A dropdown menu currently showing "Normal".
 - Due Date:** A date selection field with a calendar icon.
 - Close Date:** A date selection field with a calendar icon.
- *RCA:** A field containing a tag "RCA/ACA-21-00090" with a close button (X).
- Action Plan Description:** A large text area for describing the action plan.
- Assigned To:** A search field with the placeholder text "Search Contacts..." and a search icon (Q).
- Progress Notes:** A large text area for tracking the progress of the action plan.

At the bottom of the form, there are three buttons: "Cancel", "Save & New", and "Save".

The ACA for Leaders



1. Briefly investigate the event

Assessment

Situation/Background ⓘ

Immediate Actions Taken ⓘ

Gaps/Deviations ⓘ

Apparent Cause Statement ⓘ

Significance & Possible Extent of Cond ⓘ

1

2

3

4

5

2. Identify the gaps or deviations

3. Develop an apparent cause statement


4. Describe significance of the occurrence

5. Identify Action Plan for Improvement

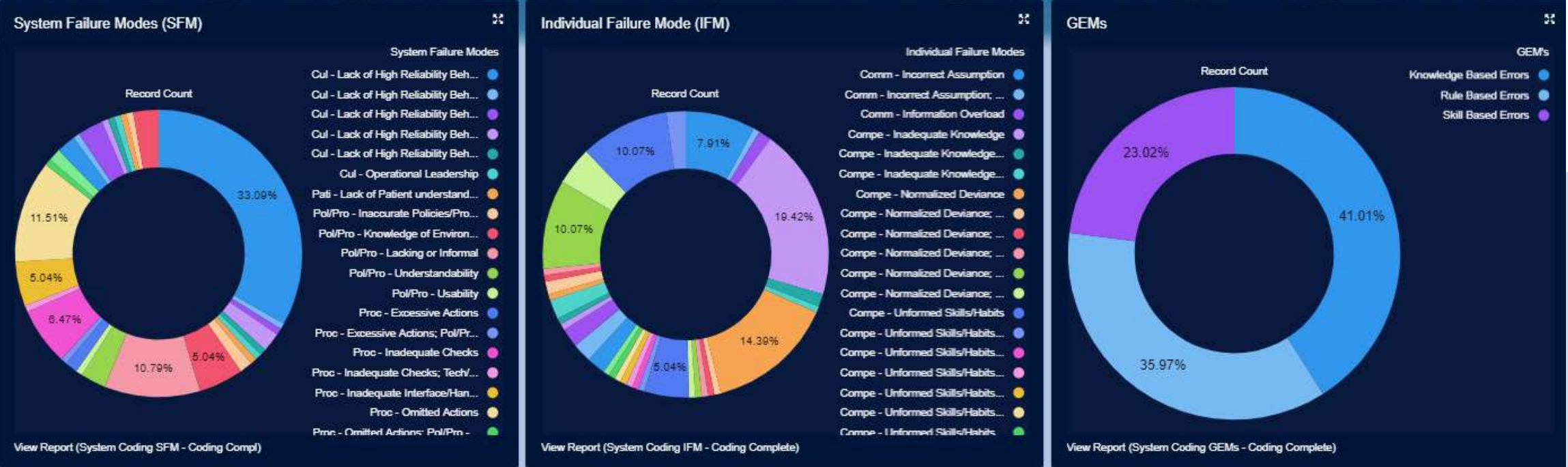


Allina Health

Organizational Learning & Enhancing Safety
Culture



Riskonnect Automating the Common Cause Analysis



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!

CONNECT WITH ME.

Juliana Aadland MS, RN, CPHQ

e: juliana.aadland@allina.com

w: allinahealth.org/

in [juliana-aadland-52a556b0/](https://www.linkedin.com/in/juliana-aadland-52a556b0/)

