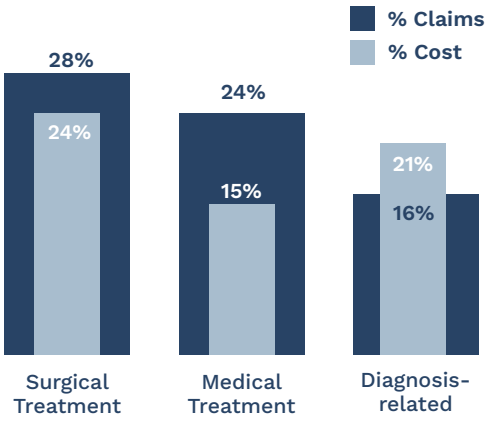
RISK REPORT

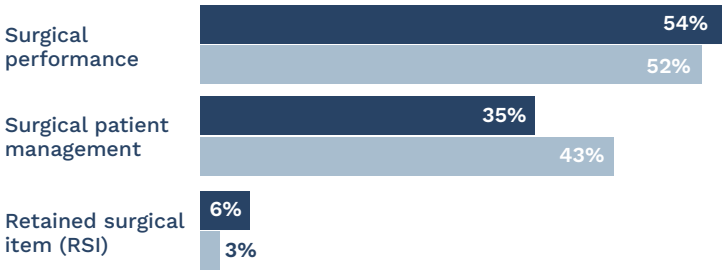
# Reducing Surgical Adverse Events

In an analysis of our medical professional liability (MPL) claims*, surgical allegations are **#1 in occurrence and #1 in cost.**

## Allegations Triggering All Claims




## Allegations Triggering Surgical Claims

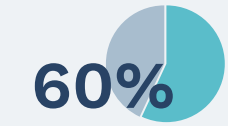



**Surgical performance** - Occurs in the operating room

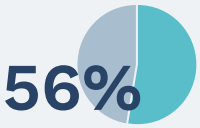
**Surgical patient management** - Steps taken pre-, intra-, and postoperative

**Retained surgical item (RSI)** - Unintended retention of an item

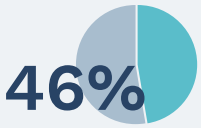
## Snapshot of Surgical Claims % Claims



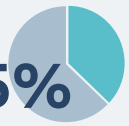
**60%** of performance claims involve intraoperative technique including known procedural risks



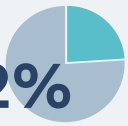
**56%** of management claims involve patient assessment issues



**46%** involve musculoskeletal or digestive procedures

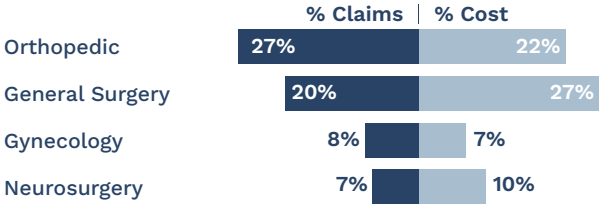


**35%** involve communication breakdowns



**22%** are high-severity events including death

## Specialties, Teams, and Locations Involved




**44%** of surgical adverse events originate from care provided in the operating room

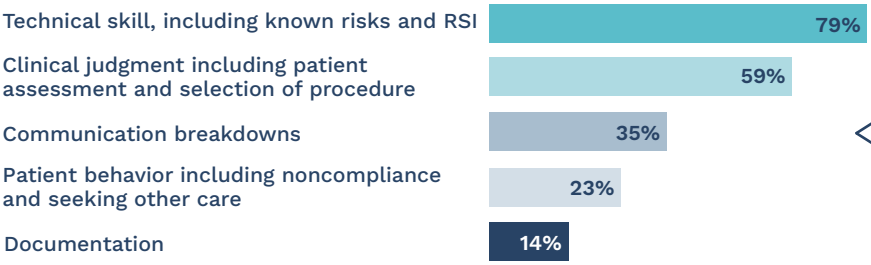
**23%** from care provided in ambulatory or day surgery centers

**13%** from care provided in a clinic



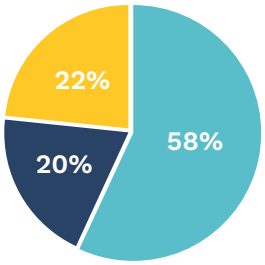
*Data from subset of Curi claims reviewed through 12/31/23 (Not inclusive of all Curi claims)

### Contributing Factors**




**One claim can have several contributing factors identified

### Communication Breakdowns




With patient/family | Among the team | Both

## Clinical Analysis Reveals Factors Driving Claims

### Preoperative decision-making and communication challenges

- Failure to use clinical decision support tools to assess surgical appropriateness/readiness/risk
- Ineffective informed consent process including expectation and goal setting

### Intraoperative technical skill and complications

- Failure to have situational awareness and recognize a known procedural risk during surgery
- Experience issues – outdated technique, inexperience with new procedures or equipment
- Equipment issues – operator error, equipment malfunction
- Failure to have or follow procedural checklists

### Postoperative judgment and communication failures

- Patient assessment and monitoring failures
- Hierarchical and handoff communication challenges
- Lack of strong patient safety culture
- Poor critical thinking skills
- Postoperative discharge instruction and communication failures

## What You Can Do To Reduce Surgical Adverse Events

**LEARN** about the causes and contributing factors to surgical events and claims

**ENSURE** surgeon technical skill with a robust credentialing and privileging process

**ENHANCE** communication with patients and among the surgical care team

**ANALYZE** surgical harm events and implement strategies to reduce risk

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