PHYSICIANS | CLINICS | HOSPITALS | SURGERY CENTERS

Risk Report

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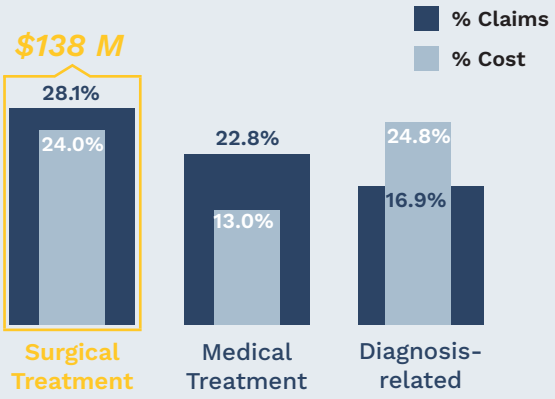
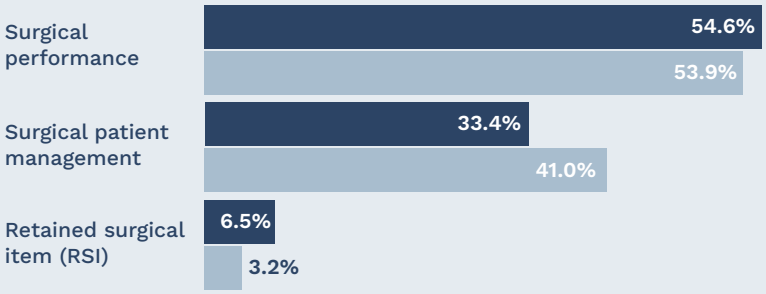
Reducing Surgical Patient Harm Events

In an analysis of our medical professional liability (MPL) claims*, surgical allegations are **#1 in occurrence and #2 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

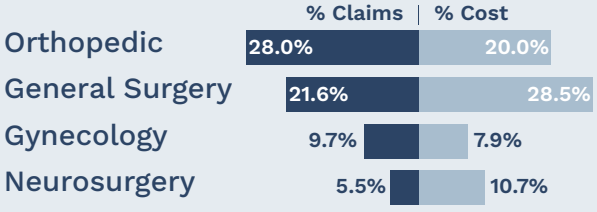
56% of management claims involve patient assessment issues

46% involve musculoskeletal or digestive procedures

35% involve communication breakdowns

24% are high-severity events including death

Specialties, Teams, & Locations Involved



44% of surgical patient harm events originate from care provided in the operating room

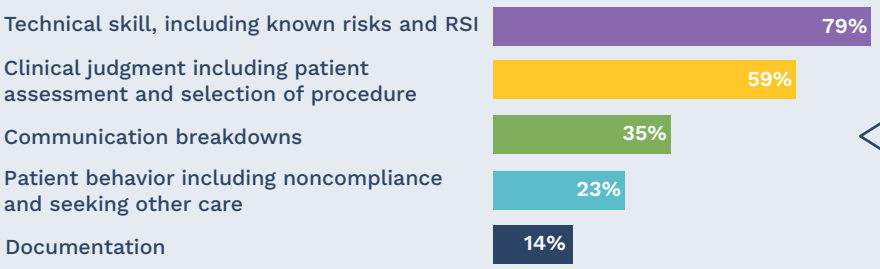
26% from care provided in ambulatory or day surgery centers

12% from care provided in a clinic

 Surgical Claims — Prospect 10/2023

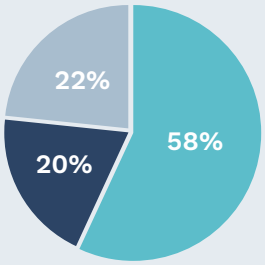
*Former Constellation Inc. claims reviewed 12/31/2020

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 Harm Events

LEARN about the causes and contributing factors to surgical harm 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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