Risk Management, Event Reporting, and Quality Improvement

Risk Management

Introduction
Decreasing risk and future loss to the organization is the responsibility of the entire organization. Every department can do their part by performing their job appropriately and following all policies and procedures. When healthcare providers work together to provide the best patient care that they possibly can, risk is considerably lowered. Documentation can save a healthcare provider in a lawsuit or it can prove the plaintiff attorney's case. Every day is a new day that brings with it new patients, new problems, and several difficult situations to overcome. Face each day with a positive attitude and the knowledge that Risk Management is there for you every day behind the scenes helping to control losses to the organization.

This educational offering is intended neither to provide legal advice nor to serve as a professional standard. In addition, consideration of all state laws and statutes is beyond the scope of this publication. It is recommended that consultation with legal counsel be obtained for advice on particular issues or concerns.

What is Risk Management?
Risk Management is the identification of situations that could lead to claims against the organization, taking steps to minimize the adverse effects of loss due to litigation, and maintaining of an acceptable level of risk.

The Risk Management department will assist in the identification of high risk areas and monitor related trends, in order to plan and implement corrective actions that will improve future patient care.

Benchmarking is another trending tool that is used by Risk Management to develop, implement, or sustain quality improvements.

Additionally, the maintenance of safe and secure work environments and protection of the organization's assets are duties of the Risk Management department. Because the healthcare provider has the front line primary accountability of patient care, the Risk Management department is a resource for information, support, and guidance when a healthcare provider is in need of assistance.

Responsibilities of the Risk Management Department
In order to appropriately monitor and decrease any possible risks and prevent losses to the organization, Risk Management must become involved in several key areas:

Policies and procedures

When policies and procedures are being created or reviewed for possible revision, Risk Management must evaluate the final product for any possible future risk in relation to these policies. The goal of writing policies is that they must be consistently attainable for those that must follow the policies. The reason for this is that if you do not comply with your policies and procedures, you will then be *in breach of policy*. A breach of a standard of policy is one of the elements of negligence which can assist the plaintiff attorney (the patient's attorney) in proving negligence in any lawsuit filed against you.

Incident reporting

Risk Management must maintain an Incident Reporting System. Incident reports are used:

- As a non-punitive tool used to identify potential liabilities and correct them before becoming a loss to the organization
- As a tracking tool for trending information to determine the frequency and severity of specific adverse occurrences
- To plan corrective actions to further the improvement of processes and promote safer patient care
- To give Risk Management a head start on claims prevention and claims management.
- In the Peer Review Committee meetings to determine remediation, counseling, education, and or discipline. Peer Review is a process whereby the quality of the services provided by the healthcare staff is evaluated by equivalently trained personnel.
- To meet the requirement for annual reporting of incident reports to specific national regulatory associations

Depending on specific state law, the incident report is a confidential document that is protected from discovery in a lawsuit at all cost. The incident report should **never** be copied and **never** be placed in the patient chart. It should also **never** be referred to within the patient chart. Three examples that require an incident report are patient falls, medication errors, and wrong site surgery.

Regulatory and contract compliance

The Risk Management department will assist in the compliance of current laws and regulations as well maintenance of current certifications of regulatory organizations such as Joint Commission. The Risk Manager will support human resources in their role of medical staff credentialing and reappointment as well as maintaining representation on several facility committees including Quality Improvement. The Risk Manager will additionally review all facility contracts and advertising for possible risk and appropriate verbiage.

Education

Education of the staff is extremely important as a method of risk control because an educated staff will be more apt to follow policies and understand how to decrease liability in their daily practice.

Risk Financing

This includes the selection of insurance coverage, the type of insurance, and the review of specific insurance carriers. The Risk Manager will assist executive management in these critical decisions as a vital member of the team.

Litigation and claims management

Another crucial responsibility of the Risk Management department is litigation or claims management. When a lawsuit has been filed, the Risk Manager will be involved in all stages of this process from the initial notification of a claim, or formal "notice of intent" to the final settlement or jury award. This process may take years to proceed to completion. The Risk Manager will cooperate with the defense attorney and the insurance consultant, to determine case strategy, aid in the investigation, discuss reserving of monetary funds for expenses and indemnity, and manage the file to conclusion.

The Risk Management Process
Risk Identification is the first step in the Risk Management process. Potential problems prior to a patient injury or actual problems that can result in a loss to the organization are identified through the use of many different systems.

Some of the risk identification systems will include occurrence or incident reports, patient complaints, performance improvement indicators, satisfaction survey reports, personal inspections, infection control, sentinel event tracking, failure mode and effect analysis (FEMA). In failure mode and effect analysis, processes associated with hazardous procedures, patient types, and other high risk processes are examined to identify weak points before a problem happens. A number of these processes can have serious ramifications if a failure occurs.

RCA Root Cause Analysis deals with incidents while FMEA deals with potential areas of risk. Failure Mode and Effect Analysis is a way of identifying potential risks. It is a tool that the Risk Manager can use to review the risk of possible solutions prior to the completion of the pilot stage.

1. Risk Identification
   Once collected, all of the above areas of identification are then documented.

2. Risk Analysis
   Risk Analysis is the second step of the process. It is now time to determine the potential severity of the loss associated with the identified risk, the probability that such a loss will occur, and the frequency of such a loss. Alternative risk techniques must be evaluated. Some techniques include a form of risk control, one of which is risk avoidance, where you never undertake the risk. This completely stops the loss from happening. Other risk controls, may lessen the severity of the loss. Risk financing consists of ways of paying for the loss after it has occurred.

3. Risk Treatment
   In the third step, the severity of the loss and the possible risk techniques has been analyzed. A risk treatment and corrective action plan will now be implemented. Some corrective actions may include policy and procedure changes, process redesign, in-service education, or patient relations. If Risk Avoidance is chosen as the risk treatment, an example would be if a facility no longer maintains a Labor and Delivery department. In Risk Financing, the cost of the risk is transferred to an insurance company.

   After you have implemented your risk treatment and corrective actions, you must perform the final step in the process. As in other familiar processes, the last step is evaluation.

4. Risk Evaluation
   In the final step, consists of monitoring your loss control and corrective action plan. Risk Management must evaluate and assess the effects of the implementation plan annually. If the corrective action plans and risk treatments are found to not be as successful as anticipated, the Risk Manager will repeat the complete Risk Management process.

Negligence
Negligence is the failure to do what a reasonable prudent person exercising ordinary care would do under similar circumstances. This would include a failure to meet the standard of care or a breach in the standard of care. In order for the plaintiff attorney to prove his case of medical malpractice he must establish that he has proven all four elements of negligence.

The four elements of negligence are:

1. Duty
2. Breach
3. Proximate or direct cause (causation)
4. Damage or Injury

- The law implies that you have a duty to exercise reasonable care whenever a patient-provider relationship has been established. This relationship may be formed just with the exchange of communication with the patient. Applicable state laws must be consulted to determine the parameters of the relationship.
- A breach of the duty occurs when there is a failure to conform to or meet the applicable standard of care. The standard of care may be determined by facility policies and procedures, national or professional association standards, state licensing regulations, or even your job description. It is important to know that the standard of care in a medical malpractice trial will be established by expert testimony. There will always be a testifying expert permitted to attest to the prevailing standard of care. A medical malpractice trial will also include an expert to attest to the causation of the injury which brings us to the third element of negligence, causation.
- Causation will require the plaintiff to prove a reasonably close proximate causal connection between the alleged conduct and the resulting injury. Causation is the most difficult connection to prove. It must be proven that if not for the actions or inactions of the healthcare provider, the injury would not have occurred. The element of causation is also established by the expert witness testimony at trial. There is one injury that is under the exclusive control of the defendant and cannot occur without negligence. This is called "Res ipsa loquitor", which is Latin for "the thing speaks for itself". One common example is a retained foreign object left in during surgery.
- The fourth element, damages related to the injury, consists of several different categories. There can be economic damages which consist of monetary losses caused by the alleged injury. Monetary losses may include loss of wages, medical bills, or future expenses of medical care, and possible hired help for household chores. Other damages can be those such as pain and suffering, loss of companionship, loss of consortium and many others that are intangible and do not include monetary losses. Punitive damages are less common. These are damages that are assessed on a defendant for possible gross negligence or wanton disregard in the care of the patient. Many feel that these are meant to punish the defendant.

Please remember that there is a recent trend to include your organization in a lawsuit by naming the corporation separately. Corporate negligence is the failure of a hospital or organization to fulfill its responsibilities to exercise safeguards that would protect against injuries to patients or staff. The organization owes the patient a duty to take reasonable care in making sure that its healthcare providers are qualified to provide proper treatment.

Strategies for reducing the risk of being named in a lawsuit
The best way is to perform safe practice and follow the appropriate standard of care for all patients every day. In a perfect world, this would be a very easy feat to accomplish but as we all know, life is not perfect.

Documentation

Documentation is the one most important factor that you must consider when attempting to decrease your risk. The patient chart is a multidisciplinary tool for the purpose of taking care of the patient. Documentation is a means of communication between healthcare providers.

The 5 C's of Risk Management rules of documentation are to be Correct, Complete, Concise, Consistent, and Cautious.

- Do not be defensive or argumentative in the record. If you are not going to take an action, do not write that you are going to take action.

- Make sure all of your notes are legible. It can be construed as negligence if the record is not legible. Do not use unauthorized abbreviations.
- Some other guides to follow related to your charting are to

  - Use ink
  - Never erase an entry; cross out the incorrect entry with a single line and initial it, provide the date and time for all entries,
  - Do not leave blank lines on the medical record,
  - Use a "late note" for matters charted out of sequence.
  - Document what is seen, heard, felt and smelled, thought processes, and non-compliant behavior.
  - Documentation should be objective. Refrain from including opinions or personal comments.

If done correctly and appropriately a nurse's charting in the medical record is the best defense in the event of a lawsuit. On the other hand, if a healthcare provider documents inappropriately or does not document at all, this can be the main focus of a plaintiff attorney's malpractice case.

Work within your scope of practice

Many times in your practice you may be asked to float to another floor or unit. When you are asked to work in an area that is not within your scope of practice or in which you have never had any experience, you should contact your supervisor and request that you work in this area on a "Helping Hands" basis. In this capacity you will still provide the needed assistance to the unit, but will not be put in a position of direct patient care in a totally unfamiliar area of practice.

In many states, your license may be sanctioned if you accept an assignment that is outside your own scope of practice. Please refer to your own state licensing organization and your state specific Nurse Practice Act for appropriate information. In a medical malpractice trial, the primary responsibility for accepting the assignment in an unfamiliar area of practice will be yours. As a patient advocate, it is your responsibility to assure that you have the requisite skills to provide care to any patient to which you may be assigned.

With the current nursing shortage, more hospitals may ask nurses to take assignments outside of their scope. The hospital will then share a portion of the principal responsibility for sending the nurse to this unfamiliar area.

When an incident occurs

When an incident occurs, there are several things that may happen.

Initially, an incident report should be written. This should be a confidential document from Risk Management. As previously stated, it should **never** be copied, **never** be placed in the patient chart, and **never** be referred to within the patient chart.

After this, you should not write any statements, give any formal statements, or sign any statements. Your charting should be appropriate and complete as per the listed guidelines stated above.

You should no longer discuss this situation with anyone without the expert guidance of your employer's Risk Management department. If you are ever contacted by an attorney or investigator in relation to any past or present incident, please contact your employer's Risk Management department immediately.

Quality Improvement

The concept of quality improvement
An organization is a system made up of many parts, and each part has a specific role to play within the organization. Processes, such as admitting patients or providing meals to patients, are things that help the organization accomplish its goals.

A Process is all of the steps involved in doing a particular procedure or task, and it may involve more than one department. For example, the process of admitting a patient is all of the steps that go into admitting the patient.

1. The patient gets the admission order from the physician office and walks into an Admitting Department.
2. The volunteer has them sign in and wait.
3. An admitting clerk calls them into the admitting area and has them answer questions and sign papers.
4. Someone from Transportation takes them up to their room and gives the paperwork to a staff person.

Quality improvement ensures that an organization's processes are designed to fulfil its goals. It entails looking at the mission, values and goals of the organization to determine whether its processes could be improved.

Mission
An organization's mission is its purpose. It is usually written as a vision statement. For example:

- "It is our mission to be a leader in healthcare, providing quality care for the community."

Values
An organization's values are qualities the organization considers important to its operation. For example:

- "We take pride in providing courteous, prompt service to our clients."

Goals
An organization's goals state specific actions to be taken by the organization. For example:

- "Goal #1: To expand services to the community during evening hours"
- "Goal #2: To develop a cardiac care center for the community"
- "Goal #3: To decrease the number of days patients remain in hospital."

All departments contribute to an organization's mission and goals. The organization's values should be reflected in each department.

Quality improvement, sometimes called performance improvement, is the study and improvement of **processes** to help an organization achieve desired **outcomes** to better meet the needs of its clients.

A Process is all of the steps involved in doing a particular procedure or task (such as admitting a patient). It is a series of actions that leads to a particular result.

Desired outcomes must be MEASURABLE to determine what processes need to be improved. Examples of measurable outcomes are:

- "To reduce the length of waiting time in the clinic"
- "To reduce the length of time it takes to admit a patient"
- "To assure correct meals are delivered to patients"
- "To reduce the number of hospital acquired infections."

Outcomes must be measurable to determine what processes need to be improved.

The focus of quality improvement is not on the people, but on the process. It is designed to determine what areas of service must be improved. Quality improvement involves gathering and analyzing data to see if outcomes are consistent with the mission, values and goals of the organization. It also determines whether outcomes are in line with established benchmarks for the industry. Benchmarks are industry standards by which an organization's outcomes are measured.

For example:

- "Are waiting times in the emergency department of your organization comparable to the waiting times set as standards within the healthcare system?"

Implementation of Quality Improvement

The Joint Commission mandate to healthcare organizations

The Joint Commission mandates that healthcare organizations systematically:

- Monitor and evaluate the quality and appropriateness of care
- Pursue opportunities to improve patient care
- Resolve identified problems.

Organizations must have a written plan that describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluating, and problem-solving activities.

Organizations have adopted various methods and plans to monitor processes, improve processes, and solve problems. Terms referring to these plans include Continuous Quality Improvement (CQI), Total Quality Management (TQM), and Performance Improvement (PI).

Planning for quality improvement implementation

To implement a quality improvement plan, an organization must design processes, monitor performance through data collection, analyze current performance, and improve or sustain improved performance.

Organizational leaders establish priorities to determine what processes should be reviewed and improved. Each organization has its own policies and procedures for conducting reviews and setting priorities. Priorities may be based on:

- Mission, values and goals of the organization
- Patient satisfaction surveys
- Data collection (infection control reports, autopsy results, etc.)
- Risk management (events that became risks, such as safety concerns, medication or treatment errors, etc.)
- Patient demographics/diagnoses (analyze top diagnoses and patient outcomes)
- Pain management methods (appropriateness and effectiveness)
- Employee opinion/needs surveys
- Quality control.

Once problems have been identified, organizations use teams made up of staff members from each involved department to study the problems and formulate plans for improvement. The focus is on the process, NOT on people.

An implementation model
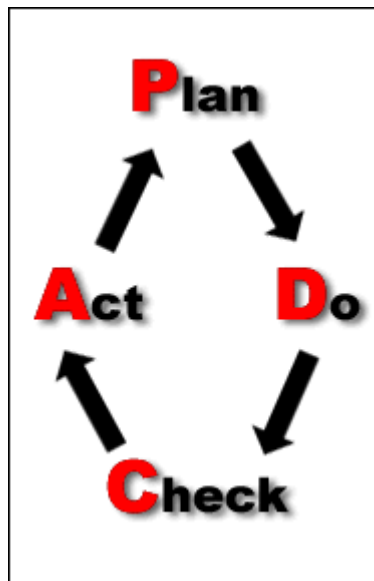
Quality improvement should entail a constant cycle of continuous

improvement. One model is PDCA: Plan, Do, Check and Act.

Quality improvement should entail a constant cycle of continuous improvement. There are many different models on which to base the implementation of a quality improvement program. A model often used is "PDCA," which stands for:

- Plan
- Do
- Check
- Act.

Plan
Once a problem has been identified, look at the processes involved. If the processes involve more than one department, employees representing each of the involved departments should be members of the quality improvement team. They should collect data, determine where, how, and why the problem is occurring, and develop a plan to correct the current processes. Desired outcomes must be measurable. Outcomes after implementation of quality improvement must be compared with the initial data collected to determine if desired outcomes have been achieved.

Planning also includes training people to use the solution, determining when the solution will be implemented, acquiring necessary equipment, forms or other supplies, and possibly organizing a pilot program and analyzing results.

Do
Once the plan is complete, carry it out.

Check
Collect data to determine if outcomes have improved. For accurate comparison, data should be collected from the same sources using the same collecting and analyzing methods used during the initial data collection.

Act
If the new processes generate an improvement, implement them. If results of the new processes are not meeting the desired outcomes, the "PDCA" cycle must be repeated with a modified plan.

Example:

- Problem: Lab tests are not being performed at the ordered time.
- Program: Identify specific problem and assemble team.
- Plan: Collect data to determine how often it occurs, which nursing units are involved, which (if any) specific tests are involved, when tests were ordered, how tests were ordered, how tests are scheduled in the lab, and how tests are performed on the patient. Include how the problem affects mission, values, and goals; barriers to solving the problem; and impact on patients.
- Do: Train staff, change the process, do a pilot study or run on a trial basis.
- Check: Collect data in same manner as initial collection and compare results.
- Act: If process works, implement overall change. If process does not work, begin again with a modified "Plan."

End of Risk Management and Quality Improvement Lesson