HealthcareSource Contingent Talent Management℠

Risk Management & Legal Issues in Healthcare

Core Competency Inservice

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Introduction

In any industry, risk management and legal issues can arise. Risk management addresses liability, both proactively and reactively. Proactive focuses on preventing risk, while reactive focuses on minimizing loss or damage after an adverse event. Risk management is a systematic process aimed at reducing accidents, injuries, and financial risks in the hospital. This helps to prevent, and properly handle, patient, visitor, and employee adverse events. Risk management cannot possibly eliminate all risk, but it can help increase quality assurance.

The healthcare profession is one of the most legally scrutinized professions and has some of the strongest ethical guidelines where legal issues can arise. Healthcare requires this type of oversight, not only because the very lives of people are at stake, but also because of the vulnerability of many of the people being cared for within the industry

Risks to patients, staff, and organizations are prevalent in healthcare. Thus, it is necessary for an organization to have qualified healthcare risk managers to assess, develop, implement, and monitor risk management plans with the goal of minimizing exposure. There are many priorities to a healthcare organization, such as finance, safety and most importantly, patient care.

Risk Management

- Improves quality of care
- Helps respond to unsafe conditions
- Protects employees and patients
- Assures resources are spent to support patient care rather than covering losses
- Reduces cost

Risk Management Plan

Continuous research is needed to identify and measure potential adverse events. Once this is identified a plan is designed and implemented to avoid risk and/or minimize damages or loss. Risk management must be tailored for each individual organization. An organization's purpose, mandate, size, facility construction, nature of business, location, patient populations, demographics, and other factors must be considered. Health care risk management can benefit from available practice guidelines and principles. Incident reports also knows as occurrence reports, safety reports or risk reports, also help recognize areas for improvement and become a part of the risk management documentation.

Given that each organization faces unique challenges, there is not a one-model-fits-all risk management solution. Challenges faced by administrators that should be addressed in a risk assessment plan include but are not limited to:

- Patient safety
- Mandatory federal regulations
- Potential medical error

- Existing and future policy
- Legislation impacting the field of healthcare

The hazards of not preparing for potential issues can have significant, long-term effects. Neglecting to have comprehensive risk management plans in place can compromise patient care, increase liability risks, and result in financial losses.

Thus, potential risks have to be evaluated and measured in terms of their potential negative effects. Based on the risk assessment, an organization-specific management plan should be developed, implemented, and monitored.

Risk analysis research to identify potential adverse events should include, but is not limited to:

- Analyzing what could possibly happen
- What is the likelihood of that event occurring
- What would the estimated outcome be if the event occurred
- What can be done to prevent the event from occurring
- What can be done to lessen the potential for the event occurring
- What, if anything, can be done to reduce the impact of the event
- What, if anything, cannot be protected or prevented

Incidents and Reporting Guidelines

Incident, Occurrence, Event Report

Engaging health care professionals and staff around reporting errors to reduce risk and improving the safety culture is a crucial but difficult task for many organizations. Unless staff members are engaged, feel safe to speak up, and are enabled to learn from the occurrence of preventable medical errors, poor patient outcomes will likely continue to occur. How organizational leaders respond to safety events and communicate to staff, patients, and family members following such events is key to building high reliability organizations and enhancing safety cultures.

An Incident (occurrence or event) Is:

- Any unusual event involving patients, employees, visitors, or contractors.
- Any unexpected medical injury, intervention, or impairment.

An incident (occurrence or event) report helps prevent negative events from reoccurring by helping us to understand the causes and circumstances surrounding the incident. Once an incident is reported and analyzed it can be used to develop educational interventions to train employees to avoid future incidents. Each incident report can also be used to assist with insurance or legal investigations.

Do's of Incident Reporting

- File a report immediately when you identify any incident
- Limit your report to facts, and do not make judgments or report opinions
- The report is, and should remain, confidential

- All information is used to benefit the performance improvement plan

Do Nots of Incident Reporting

- Do NOT place the report on the medical record
- Do NOT make copies of the report
- Do NOT discuss the report with others
- Do NOT state in the chart that the report has been made
- Do NOT hide any facts

Safety Events and Root Cause Analysis

Patient Safety Events

- **Patient Safety Event**: An action, or lack of action, that could have resulted in, or did result in, patient pain or injury.
- **Adverse Event:** A patient safety event that caused pain or injury to a patient.
- **Sentinel Event:** A type of Adverse Events that caused death, permanent damage, or severe temporary pain or injury.
- **No-Harm Event:** A patient safety event that actually reaches a patient but does not cause any injury or pain.
- **Near Miss:** A patient safety event that never reaches the patient.
- **Hazardous conditions:** A circumstance, unrelated to the patient's disease, that increases the chance of an adverse event.

An incident report is required for every serious adverse event (sentinel event) to help prevent risk and the reoccurrence of risk. Should such an event occur at health care facility will conduct a thorough investigation (Root Cause Analysis) to establish the cause of the event. This will help the facility learn how to change the process or system to prevent similar events from occurring in the future. If you were involved in the incident, you may be asked to participate in such an analysis. The findings from this analysis will be reported to the medical staff and to the governing board of the hospital.

When in doubt, fill it out! An incident report is not to lay blame for an event that occurred, or almost occurred, but rather to facilitate learning and performance improvement. Not completing an incident report could cause the facility to miss out on learning or improvement opportunities. If you are unsure, complete the incident report for any patient safety event and your supervisor will determine whether what happened is an incident or not.

Risk Reduction

Many patient risks can be reduced by adequately training physicians and staff, encouraging strong communication among staff-members, providing counseling services for those working with patients, and conducting competency assessments.

Other risks posed to patient safety can be mitigated using patient-specific risk management strategies such as:

- Encourage reporting and a culture of safety
- Produce a rapid and standardized response to identified concerns
- Empower managers to address issues close to the source
- Promote greater transparency

Sources Used to Interpret the Law

Standards of Care

Standards of care are the level, or quality, of care considered appropriate by a profession, based on the skills and learning commonly possessed by all members of a profession. Standards of care are the minimal requirements that define an acceptable level of care. All hospital professionals must abide by these regulations to help ensure quality care is given to all patients, and that no unnecessary harm comes to any patient. Failure to meet these requirements is called neglect.

Practice Acts and Standards

Practice acts and standards are created by each state and define healthcare professions' legal scope of practice. These rules and regulations help protect patients from harm by governing health professionals' education standards, licensing requirements, professional duties, professional rights, and disciplinary actions for disobedience. State boards, of every heath profession, publish acceptable standards in practice acts relevant to each individual discipline. These rules and regulations have the force of law because they are met or violated based on evidence presented.

Professional Position Statements

Professional position statements explain, or justify, why a decision was made, or action was done. Professional organizations publish their own position statement to the body of their standards of care.

Policies and Procedures

This is a standard set forth by an individual institution as the minimal acceptable practice. In court cases, institutional policies and procedures are presented and evaluated to determine if a clinical defendant has met the standard of care set forth by the institution.

Negligence vs Malpractice

Negligence

Negligence is a general term that means failing to act as a reasonable prudent person would act. Negligence is when a healthcare professional deviates from the set standards of care in which any reasonable person would use.

Malpractice

Malpractice is a form of negligence when a medical professional, purposefully or accidentally, mistreats a patient. The wrong or injudicious treatment must result in injury, unnecessary suffering, or death to the patient. Malpractice can stem from ignorance, carelessness, lack of proper professional skill, the disregard of established rules, neglect, or a malicious/criminal intent. These purposeful or accidental acts can potentially impact the health, safety, and finances of a patient. When this happens, a liability exists which can result in a lawsuit being filed against the healthcare professional whether they acted in good faith or not.

Documentation

Proper documentation can protect healthcare professionals, just as lax documentation can weaken a defense during a lawsuit. What happened, when did it happen, and why did it happen, are fundamental questions that must be answered in every potential claim. Sloppy documentation can hamper a healthcare professional's ability to defend their answers to these questions. Proper documentation is a healthcare professional's best defense in any legal issue. **Documentation must be precise and true. Improper or false documentation could lead to a lawsuit.**

The Official Do Not Use Abbreviation List

The Do Not Use Abbreviation List is intended to prevent mistakes by eliminating confusing abbreviations to reduce error and medication mistakes. When a do not use abbreviation is encountered in an order the physician must be called to verify the order then have the order correctly written.

DO NOT USE	USE INSTEAD
U	Write out "units"
IU	Write out "international units"
Q.D., QD. , q.d.,qd	Write out "daily"
Q.O.D., QOD, qod, q.o.d.	Write out "every other day"

Trailing zero (X.0 mg) Absent leading zero (.X mg)	**Write “X mg” Write “0.X mg”**
MS	**Write “morphine sulfate”**
MSO4 and MgSO4	**Write “magnesium sulfate”**
< or >	**Write greater or less than**
Abbreviations for drug names	**Write drug names in full**
Apothecary units (Drams, Scruples, Grains)	**Use metric units (Meter, Liter, Gram)**
@	**Write “at”**
cc	**Write “ml” , “mL” or “milliliters”**
ug	**Write “mcg” or “micrograms”**

Just Culture

To promote effective reporting and achieve quality care, facilities need to adopt what's referred to as a "just culture." The just culture recognizes that it's rare for any single nurse to be the cause of an incident; instead, multiple system factors often combine to create the circumstances. The just culture eliminates punitive action against the person filing out the incident report and encourages looking beyond the incident to determine other factors. These factors may include orientation and training, staffing ratios, and other issues influencing patient safety.

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