Hello, class. As you know, my name is _______. We are going to spend this session talking about quality assurance and risk management.

2 Concepts of Risk Management
- Prevent law suits
- Identify risk situations
- Deal with potential suits
- Communicate with attorneys
- Prevent Adverse Patient Occurrences (APO)

What, exactly, is risk management?

Risk management is a department that has been set up in many hospitals to ensure that when, an incident occurs, that it is handled appropriately by people that are trained in risk management.

The principles of risk management are to prevent lawsuits and, if not prevent them, decrease the exposure or liability.

Therefore, it is prevention and minimizing risk.

Identify risk situations. Where is the institution going wrong? Are there identifiable risks?

An example: if there are a number of patients falling out of bed at a certain time at night on a particular unit – one could determine that by looking at the incident reporting. There may be a particular unit or particular shift that is understaffed and you can identify that through the incident reports.
and help prevent that risk.

Once a lawsuit is brought, the risk management department deals with the suit or the potential for a suit. The risk management department communicates with attorneys.

Risk management tries to prevent adverse patient occurrences (APO).

We are going to talk about APO, or Adverse Patient Occurrences, throughout this Seminar.
<table>
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<tr>
<th>What is an Adverse Patient Occurrence?</th>
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| 3 Adverse Patient Occurrences  
  - An unexpected event that puts the institution at risk  
  An adverse patient occurrence is an unexpected event that puts the institution at risk. It could be a patient falling out of bed, it could be a medication error, or it could even be a potential error that did not happen but almost happened. |
| 4 Sentinel Event  
  - These are more serious Adverse Patient Occurrences  
  - Serious Reportable Events  
  Sentinel events are more serious adverse patient occurrences. They are serious reportable events. An event that resulted in a patient’s death or serious bodily injury would be a sentinel event. |
| 5 Risk Management Department  
  - Nursing Risk manager  
  - Medical records  
  - Housekeeping  
  - Operator  
  - Physicians  
  - Quality Assurance  
  - Policy & procedures committees  
  - Entire staff  
  Who makes up the risk management department? Usually there is a nursing risk manager. There may be an attorney that's part of the risk management department, the medical records department, housekeeping, the operator, physicians, quality assurance, the policy and procedure committee, the entire staff of the hospital are part of risk management.  
  You may ask:  
  How does housekeeping become part of risk management?  
  Let us say that housekeeping is cleaning the floor and they hear the patient complaining to a family member that nurse so and so is giving them lousy care. Well, that is an event that should be reported to the risk management department.  
  Why? There is a potential of risk when somebody is complaining; there is potential that a lawsuit can be brought. You can provide the best care, but if you have a lousy patient demeanor, if something miniscule goes wrong you can be sued. |
| Does anyone know what a sentinel event is?  
  Any ideas as to who is part of the Risk Management team? |
You know we talked about suit in the last Seminar and anybody can sue. They might not necessarily win, but a lawsuit causes distress. It affects retention and it costs money, so we want to prevent lawsuits. We also want to protect patients from harm.

How is the operator of the institution part of the risk management? Well, she is a front line person. People call in and say I want to speak to so and so because I am really upset about something. Well, that operator has an obligation to report that a person is upset because, again, there is a potential for suit.

The medical records department may get a request for medical records. Let's say that Mrs. Jones is complaining to Mr. Jones, and housekeeping hears it. Mr. Jones calls the operator and asks to speak to so and so, He tells the operator that the person that took care of his wife did a lousy job and he is angry. Now all of a sudden medical records gets a request from Mr. Smith for Mrs. Smith's medical records. Those are three key people; the operator, housekeeping, medical records. If they report to RM they may notice that there may be a potential risk. At that point in time those people should be communicating with the risk management department, filling out an incident report that there is a potential for suit.

There is a complaint, then the risk manager says, “oh my goodness, the operator heard from Mr. Smith, and he was complaining. The housekeeping department heard that Mr. and Mrs. Smith were complaining about care and now, all of a sudden, there's a request from an attorney for medical records”. So the risk management department puts it all together. They may be isolated incidents to you, or to housekeeping or to a physician, but when put together, it may signal that there is something coming - a lawsuit.

What can be done? The patient needs to be
talked to by somebody who is maybe in the risk management department who knows what to say. They may say, "Mr. and Mrs. Smith, I hope your care here has been satisfactory. Is there anything that we can do to help?"

Just that type of a statement to them may open up a flood of information and this situation can be resolved. That's identifying risk and acting on it.

6 Quality Assurance Department
• The QA department looks for potential risk
• Reports potential risk situations
• Integral part of Risk Management
• Looks for quality of care and continuity of care
• Create a culture of safety
• Works with risk management to perform Root Cause Analysis (RCA)

The Quality Assurance department works with the risk management department and quality assurance looks for potential risks when they are reviewing records and reports. They report potential risk situations. They may see something when auditing medical records; that is a pattern and they need to report those patterns to risk management. They are an integral part of the risk management network. They look for quality care and continuity of care. They are there to create a culture of safety. They may work with risk management to perform a root cause analysis. A root cause analysis, or an RCA, is an analysis of an error that assesses an event and identifies causes and possible solutions.

The Joint Commission created a root cause analysis matrix which includes behavioral assessment processes. These include:
• assessment of patient risk to self and others,
• physical assessment processes,
• patient identification processes,
• patient observation processes,
• care planning processes,
• continuum of care,
• staffing levels,
• orientation and training of staff,
• competency assessment and credentialing,
supervision of staff, 
communication with patients or family, 
communication with staff members, 
availability of information, 
adequacy of technological support, 
equipment maintenance and management, 
physical environment including lighting, 
distractions, security systems and procedures,
Medication management, including selection and procurements, storage, ordering, transcribing, preparing and dispensing; administering and monitoring (Finkelman & Kenner 2012 pp.140-142).

All of these need to be considered when a root cause analysis is done.

7 Tactics to Reduce Risk
- Congeniality
- Truth
- Acknowledging issues
- Listening to patients and families
- Appropriate investigation
- Appropriate documentation
- Quick investigations

What are some of the things that you can do to reduce risk of a lawsuit? Being congenial is really important. Patients have a tendency not to sue people they like. You may do something very egregious but, if the patient likes you and if their family likes you, they are less likely to sue you, because they have identified with you.

If you did something minuscule and it is not so egregious but they do not like you, they are more likely to sue you. So being congenial is being a way to reduce risk.

Truth. Telling the truth. Let’s say that the patient fell out of bed. Someone needs to go in and talk to the family members and say, "This is what happened." Do not accept any blame, but just state the facts and say that "We are trying assist your family member and determine what will make them most comfortable-- we would like to involve you in this process." Involve the patient and the family members.
Acknowledge issues. Acknowledge that something happened. Do not accept blame or place blame. Go in with somebody so that you have a witness and acknowledge that the patient fell out of bed. Simply state the facts. Do not say, “well we were short staffed and somebody should have been in there watching your mom or your wife, but we were busy with something else”. Those are the types of statements you do not want to say. Listen to patients and families. This goes a long way. What are they saying? Are they happy with your care? Are they happy with the institution? Ask them if there is anything that you can do to make their stay more welcoming.

Doing an appropriate investigation. We already talked about all of the departments that are involved but it is many more than that. It is also pharmacy, it is also the occupational therapy department, the physical therapy department; all of these areas can help identify risk and with an appropriate investigation.

Appropriate documentation. Let's say that an incident happened. You want to document the facts. You do not want to document subjective information, only objective information.

You do not want to be fraudulent in your documentation because, as we already discussed in the last Seminar, fraud can be grounds to number one, extend the statute of limitations and also, in most states, fraudulent documentation or changing medical records can be considered a crime and punishable by imprisonment.

Quick investigations. It is important to be timely. It is important to identify who the parties are. Who witnessed what happened. Who heard statements from the family members? All of those things need to be written down and maybe sent to your
attorney, and we'll talk about attorney-client privilege in a minute.

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<th>8 Mandatory Reporting</th>
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<td>States have their own laws about reporting</td>
<td>Each state has its own particular laws about reporting. Fifty percent of the states all have reporting laws. Generally, reporting is done to the Department of Health in the state.</td>
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<td>Based on protection of the public</td>
<td>The purpose of mandatory reporting is protection of the public. Many states have statutes that protect these documents from discovery if a lawsuit ensues. Other states may not have that protection, and the documents that you submit for mandatory reporting may be subpoenaed and used in a lawsuit.</td>
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<tr>
<td>Many states protect these documents from discovery if lawsuit ensues</td>
<td>The Health Department of the state may investigate an incident, an adverse patient occurrence, or a sentinel event.</td>
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<td>Health Departments may investigate</td>
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<th>9 Accreditation Reporting</th>
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<td>Joint Commission to ensure quality &amp; safety monitors sentinel events</td>
<td>The Joint Commission's purpose is to insure quality and safety and they may monitor sentinel events. As we mentioned before, a sentinel event is an adverse patient occurrence that is more serious and may be an event that results in death of a patient or serious bodily harm.</td>
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<td>May investigate events unannounced</td>
<td>Accreditation may come in and do a survey, unannounced, and they may do that survey for the purpose of safety and quality and looking for particular incidents.</td>
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<th>10 Regulatory Compliance</th>
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<td>This is state-by-state rules &amp; regulations</td>
<td>This is state by state, in terms of rules and regulations. Usually the department of health of the state will require mandatory reporting of adverse patient occurrences and sentinel events, so this is particular to your particular state, but most states have this regulatory compliance and reporting.</td>
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<td>Usually to Health Department of the state</td>
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<td>Adverse Patient</td>
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<td>Occurrences</td>
<td>11 Departments Involved in Risk Management</td>
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<tr>
<td>• Sentinel Events</td>
<td>• Housekeeping</td>
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<td>• Nursing</td>
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<td>• Operator</td>
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<td>• Maintenance</td>
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<td>• Medical Records</td>
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<td>• Pharmacy</td>
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<td>• Laboratory Personnel</td>
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<td>• Anyone in the Hospital</td>
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To recap: the departments that are involved in risk management, could be housekeeping, nursing, the operator, maintenance, medical records, pharmacy, laboratory personnel. Anyone in the hospital is part of the risk management team.

Hospital may have is an evaluation box, where patients can drop in suggestions and, sometimes, there is a suggestion in the box that there may be a lawsuit pending because of care that was not appropriate. Therefore, these are all important to consider.

Some hospitals survey their patients. Now they may have blogs or even websites that one can go to complain about incidents that happen in the hospital. These are all important to monitor.

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<th>12 Documentation</th>
<th>In terms of documentation, there is incident reporting</th>
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<td>• Incident reporting</td>
<td>It is extremely important not to place blame on any one person. Just use your five senses. What did you see, hear, smell, taste or touch? Report objectively. Do not form opinions. Do not have what I call finger-pointing battles, where you indicate that it was the doctor at fault or the doctor will report and indicate that you were at fault. That is not appropriate. You simply state the facts.</td>
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<td>• Correction of errors</td>
<td>Do not document in the medical record that an incident report has been filled out. That is a clue for an attorney to look for the incident report. Most incident reports are discoverable in a court of law under the discovery proceedings. Any information that you want to share you may want to send</td>
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<tr>
<td>• What you observe objectively - facts not subjective</td>
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<tr>
<td>• Attorney-client privilege - confidentiality</td>
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that to your attorney in a letter as a confidential letter and under attorney-client privilege. This may not be discoverable as privileged information. When you correct errors in the medical records - some people are still using paper and pencil - just draw a simple line, initial and write an error, what the error is, if charted in the wrong chart do not leave a lot of extra space for somebody else to chart. If there are extra spaces you need to draw a line through it.

Document what you observe objectively. The facts. Not subjective, not opinions. Do not have charting battles, where you are blaming another person.

The attorney-client privilege is confidential. Anything that goes to the attorney should not be discoverable and should not be shared with the opposing party.

13 Reporting Procedures
- Your institution will have set guidelines
- Facts do not give subjective information
- Do not try to cover up
- The state or facility may report the APO to the state licensing board

Your institution will have set guidelines for reporting. Again, you give facts. You do not give subjective information. Do not try to cover anything up. This makes it worse. The state or facility may report the adverse patient occurrence to the state licensing board, and what that means is your license could be in jeopardy for an incident that you are involved in and that is a separate procedure and could result in suspension or revocation of your license or a fine or monitoring.

14 Conclusion
- Try to prevent APO
- Be honest
- Report objectively, not subjectively, facts only
- Try to minimize risk exposure and cooperate with the institution's attorney.

Try to prevent adverse patient occurrences. Be honest, report objectively not subjectively. Facts only. Try to minimize risk exposure and cooperate with the institution's attorney.

How can you incorporate these concepts into your paper?
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<th>15 Questions</th>
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<td>risk of exposure</td>
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<td>• Cooperate with institution and attorneys</td>
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9 Assignment, think about the case study that you have. How can you integrate risk management into that paper? What procedures would you take to prevent the incident that you have chosen for your case study? Think about identifiable risk. Think about how the incident could have been prevented and think about once the incident has happened, how are you going to respond to this?