# Risk Management

2017 Annual Mandatory Education

Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

Miracles made daily.

# Objectives

- Discuss elements of a Just Culture
- Identify the types of incidents to report
- Demonstrate how to enter an incident report in Quantros
- Describe risk management's role and responsibilities
- Explain the types of events that are entered in Quantros
- Define Comprehensive System Analysis, Code 15 Events, Chain of Command, Two Person Rule
- Describe how to contact Risk Management

# Just Culture

- To reduce harm to the next patient through creating an environment in which employees  are comfortable sharing lessons learned from personal errors without fear of retribution.
- The goal of Just Culture is to allow people to acknowledge and learn from their mistakes
  - You cannot have a zero tolerance for errors if you have Just Culture
- This is not a “blame-free” approach to adverse patient safety events; “society rightly requires that some actions warrant disciplinary or enforcement action”.

**Just Culture balances the need to learn from our mistakes and the need to take disciplinary action…”**

*David Marx, Patient Safety and the “Just Culture:” A Primer for Health Care Executives; April 17, 2001*

# Just Culture

- The reward of a Just Culture is an engaged workforce that discusses adverse events openly and turns them into opportunities to improve healthcare
- A Fair and Just Culture:
  - focuses attention predominately at identifying and addressing the system/organization factors that impact reliability and performance;
  - provides an atmosphere of trust in which people are encouraged for providing essential safety- related information (e.g. incident, hazard and near miss reports), building a healthy reporting culture;
  - clearly defines where the line must be drawn between acceptable and unacceptable behavior; and
  - is a pre-requisite for the degree of openness that a learning and informed culture requires.

# Healthcare Risk Management

**RESPONSIBILITIES**

Investigate and analyze all incidents that occur to patients, staff and visitors within the system

- Promote a Just and Fair Safety Culture.
- Provide recommendations and measures in conjunction with quality management that eliminate or minimize risk of injury
- Facilitate event analysis, development of risk reduction strategies and sharing of lessons learned.
- Manage medical malpractice and general liability claims
- Report adverse incidents to the proper regulatory agencies
- Report allegations of sexual assault against a licensed healthcare professional to DOH
- File EMTALA violations
- Report  death in restraint to CMS
- Report  equipment malfunction
- Facilitate disclosure of adverse events
- Minimize the systems exposures to legal and economic loss

# Florida Risk Management Statute 395.0197

"Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program to include but not limited to:

- The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents within **3** **business days** after their occurrence.
- Per Florida Law and JHS Policy, ALL unexpected patient safety events MUST be reported by the health care personnel with the most knowledge of the event within **3** **business days.**
- **At JHS we use Quantros as a Electronic Safety Event reporting System**

# Type of Events

- Near Miss:
  - These are events that could have caused harm to the patient but never reached the patient
- Actual Event:
  - Any unusual occurrence that is inconsistent with the routine care and/or operation of the hospital
- Adverse Incidents:
  - Defined by Florida Law  events involving medical intervention that results in harm to the patient
- Code 15 Adverse Events:
  - Defined by Florida Law as adverse incidents with specific outcomes that are subject to mandatory reporting within 15 calendar days of occurrence

# Examples of Actual and Near Miss Events to report

- Wrong site/wrong patient surgery
- Falls
- Medication error
- Retained foreign body
- Patient misidentification
- Blood transfusion reaction
- AMA Discharge event
- Transfer to a higher level of care
- Birth Injuries
- Incorrect patient information,
- Expired equipment pulled for case
- Expired medication found
- Wrong medication pulled; but caught prior to administration
- Complication from surgical/ invasive procedure
- Unexpected death
- Death associated with restraint

# What to Report

- Just the Facts…
  - Who
  - What
  - When
  - Where
  - Why
  - How

# Reporting Guidelines Dos

Complete an incident report:

- For any identified occurrence or potential occurrence
- By the person who was directly involved or witnessed the occurrence
- As soon as possible, incident reports must be submitted 3 days
- Enter information in every required section
- Describe: Who, What, When, Where.
- Be objective
- Paint the picture
- Document any event, interventions and outcomes in the patient record

# Reporting Guidelines Don’ts

- Do not assume someone else has done it
- Do not inform the patient that a incident report was completed or that a Risk Manager has been notified
- **Do not be coerced by anyone to NOT report an event…reports remain highly confidential**
- Do not editorialize or provide opinions
- Do not accuse or assume

***Do not document or give any reference to an incident / Quantros report or discussion with risk management in the patient record***

# Where To Report

All employees can easily access the system to enter a report

- Safety Event reports are entered into our electronic reporting system, QUANTROS
- Quantros is accessible via the net portal or directly from a patient's medical record.
  - Anonymous reporting
    - If you are reporting anonymously your position title is required
  - Reporting through net portal
- Once in Quantros simply follow the command prompts.
- * fields are Mandatory

## Join Us for Employee Holiday Party Dec. 17

The 2015 employee holiday celebration at Jackson Memorial Hospital will take place **this Thursday, December 17, from 3 to 5:30 p.m., in Alamo Park**. Join us for live musical performances, a dessert buffet, and holiday refreshments; and stop by the Jackson Holiday Pop-up Store **from 2 to 5 p.m. in the Alamo** to stock up on gifts for your loved ones. A dollar from each item sold at the Pop-Up Store will go to the Jackson Health Foundation. Click **here** to see the items being sold.

## Global Applications

- Application Directory
- MIRACLE Applications
- JEN
- Kronos
- Lawson Applications
- Quantros Anonymous Reporting
- ReACT Password Reset

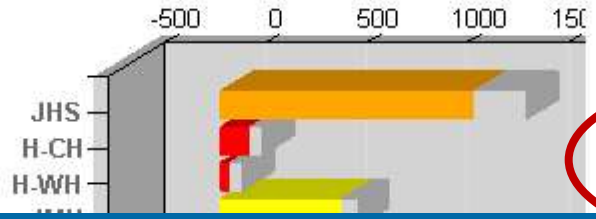
## ssion & Vision

*N, an academic health with a public healthcare*

*V STATEMENT to build the of the community by providing high standard of quality care*

## JHS Analytics

**Midnight Census Report**
Source:MIRACLE




## My Favorite Applicatio

- Application Directory
- Quantros Application

# Anonymous Reporting

Jackson Memorial Hospital (Corporate)
**Jackson Memorial - Main Campus**

# Safety Event Entry

**Event ID: EHZ12513476**

Reported on: 12/22/2016 04:13 PM
Last saved: Not saved yet

Save and Finish Later

*Indicates required fields

* When did the event occur?

Date mm/dd/yyyy ○ Today ○ Yesterday ○ Date Unknown

Time hhmm (2400h) ◉ Time Unknown

* Who was the affected party?

Patient | Employee | Visitor | ○ No person involved

* Department where the event occurred?

select ...

Was another department involved?

Yes | No

Was a neighboring facility involved?

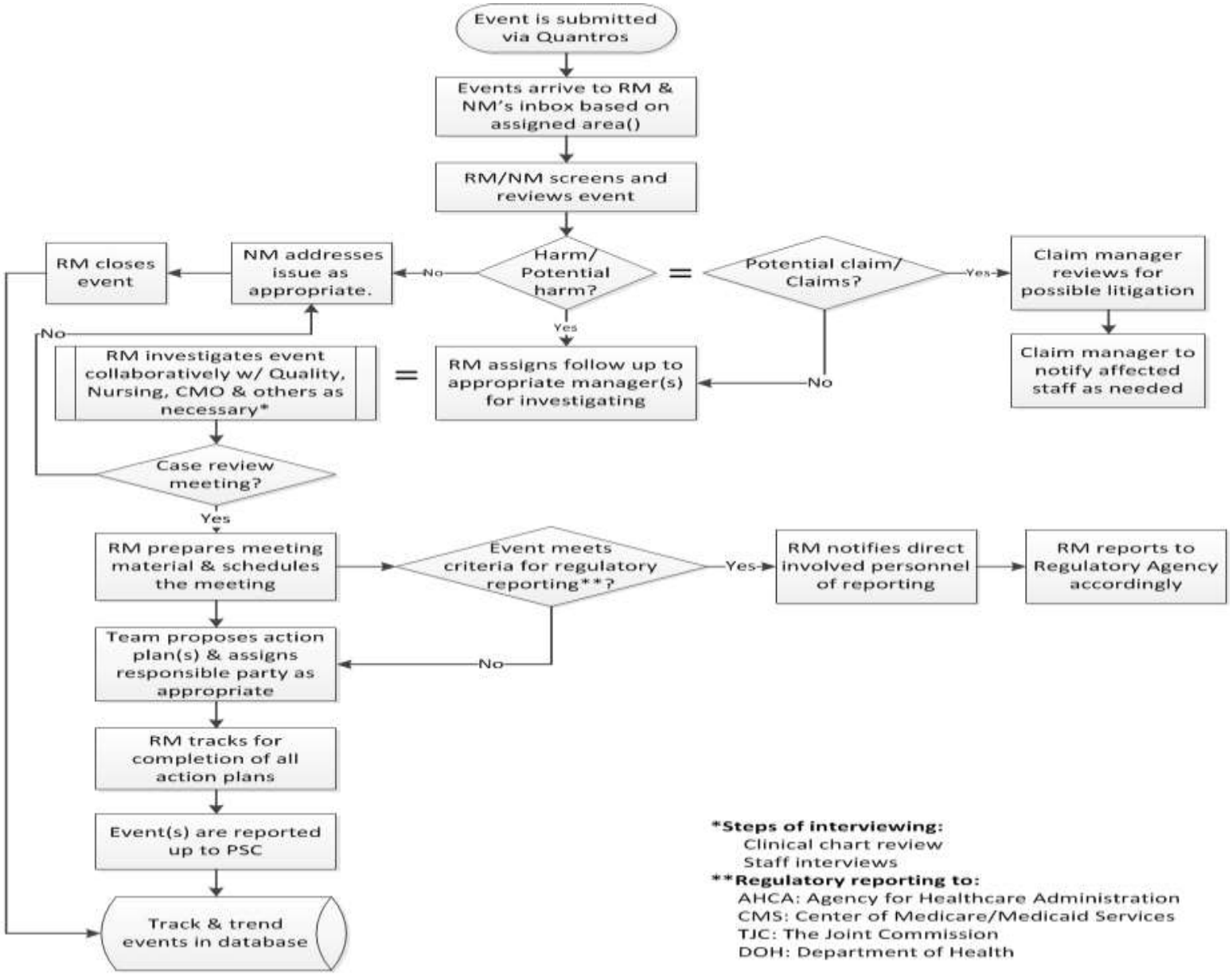
Yes | No

* Does this event involve a transplant candidate, recipient, or living donor?

select ...

* Was a physician or provider contacted in response to this event?

Yes | No


Event is submitted via Quantros
Events arrive to RM & NM's inbox based on assigned area()
RM/NM screens and reviews event
Harm/ Potential harm?
No
NM addresses issue as appropriate.
RM closes event
Yes
Potential claim/ Claims?
Yes
Claim manager reviews for possible litigation
Claim manager to notify affected staff as needed
No
RM assigns follow up to appropriate manager(s) for investigating
RM investigates event collaboratively w/ Quality, Nursing, CMO & others as necessary*
Case review meeting?
No
Yes
RM prepares meeting material & schedules the meeting
Event meets criteria for regulatory reporting**?
Yes
RM notifies direct involved personnel of reporting
RM reports to Regulatory Agency accordingly
No
Team proposes action plan(s) & assigns responsible party as appropriate
RM tracks for completion of all action plans
Event(s) are reported up to PSC
Track & trend events in database
*Steps of interviewing:
Clinical chart review
Staff interviews
**Regulatory reporting to:
AHCA: Agency for Healthcare Administration
CMS: Center of Medicare/Medicaid Services
TJC: The Joint Commission
DOH: Department of Health

# Event Follow up

A Risk Manager reviews the report on the business day following its entry. Depending on the event the following may occur:

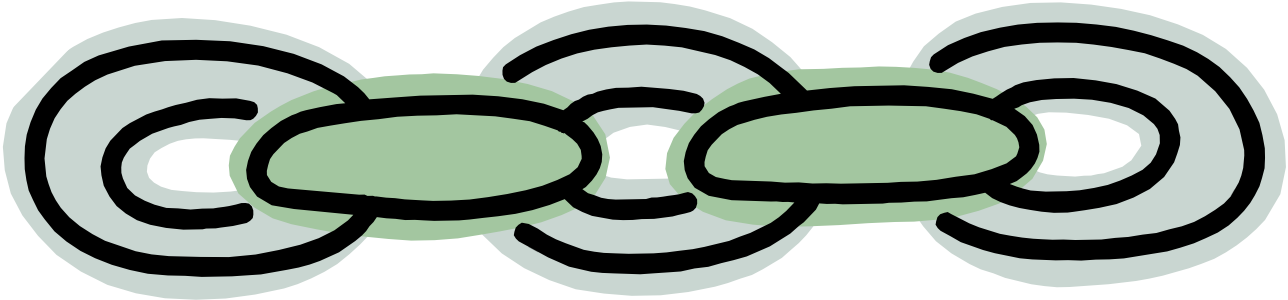
- Follow up via system assigned to the department/ nursing leader
- Investigation
  - In-person questions/ verification of facts
  - Medical record review
- Comprehensive System Analysis
  - Informal Case Review
    - Clinical physician-directed case review
    - Case review with leadership (nurse manager, specialty leader, quality or risk department leader
  - Formal Case review
    - Involved parties and content experts meet to review event and determine variances in process and together develop " Risk Reduction Strategies"
  - Root Cause Analysis
    - Is similar to a Case Review; however event has greater severity, system or hospital wide implications and can be potentially a Code 15 and or a Sentinel Event.

# Code 15 Events

- Risk Management must report within 15 calendar days of occurrence or knowledge of the following if it results from medical intervention rather than the patient's condition:
  - Death
  - Brain or spinal damage
  - Permanent disfigurement
  - Fracture or dislocation of bones or joints
  - Performance of procedure to remove unplanned surgical foreign objects
  - WRONG:
    - Patient
    - Surgical Procedure
    - Surgical Site Procedure
- In addition to the summary of the event the licensed practitioners involved with the events license is included in the report

# Comprehensive System Analysis

- Multi-disciplinary
- Focus on system vs. individual performance
- Develop Risk Reduction Strategies/ Action Plans to address identified issues.
- The majority of RCA's reveal communication breakdowns



- Share lessons learned across the system.

# Chain of Command

- The chain of command process is in place to provide interdisciplinary lines of communication to resolve a conflict in care of an individual
- It is in place to protect you as a Health Care Professional (HCP) should you feel the standard of care is not being met for a patient
- HCPs are required to communicate up through the chain of command with all appropriate persons until resolution of an issue related to a patient care standard is achieved
  - The physician chain of command: Intern/Resident, Senior/Chief Resident, Attending Physician, Chief of Service, Chief Medical Officer
  - The nursing chain of command: Nursing staff, Clinical Staff Nurse, Associate Nurse Manager, Nurse Manager, Associate Director of Patient Care Services, Director PCS,  AIC, Associate CNO, CNO
  - Other professionals' chain of command: HCP, Manager/Supervisor, Department Director, Administrator

# Disclosure

- It's the right thing to do
- It is required by State and Federal Statutes that a patient, parent or family member as  be told of any adverse incident that occurs during the provision of medical care that results in serious harm to the patient
- As per Jackson Health System policy, disclosure must be conducted as soon as possible by the attending physician whom has training in disclosure
- Proper disclosure does not constitute an acknowledgement of liability and cannot be used as evidence in a malpractice trial

# Allegations of Sexual Misconduct

- Any allegations from a patient or family member alleging sexual misconduct by a Jackson Health System employee having direct patient contact must immediately be reported to your Risk Manager and supervisor
- Police will be notified and a full investigation will be conducted
  - If the patient is a vulnerable adult elderly or a child DCF Abuse line report shall also be submitted
- If the accused is a licensed professional, accusation and investigation results will be submitted to the Department of Health (DOH) as per state law
- If the allegations, upon investigation, prove to be malicious, the person filing the allegations maybe prosecuted for a misdemeanor of the second degree. It is not up to us to make that determination
- We MUST follow protocol

# Reporting Death in Restraint/ Seclusion

- Per Federal Regulations, Part 42, Section 482.13(g), hospitals are required to report to CMS deaths associated with restraint/seclusion of each death that occurs:
  - While a patient is in restraint or seclusion, excluding 2-point soft wrist restraints
  - Within 24 hours after the patient has been removed from restraint or seclusion
  - Within 1 week after use of restraint or seclusion where the death is known to the hospital or it's reasonable to assume that the use of restraint or seclusions contributed directly or indirectly to the patient's death
- Risk Management should be notified immediately of all deaths associated with restraint/seclusion

# Equipment Malfunction

- Remove equipment form the patient care area
- Notify biomedical engineering immediately
- If patient harm has resulted, sequester all equipment involved, notify biomedical engineering and risk management immediately
- Submit a Quantros event report

# Two Person Rule

- According to Florida Statute § 395.0197 There must be more than one person attending patients in the PACU
  - EXCEPT when emergency circumstances require otherwise, against a staff member of a licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend in the recovery room and is in the company of at least one other person
- However, a licensed facility is exempt from the two person requirement if it has:
  - Live visual observation
  - Electronic observation; or
  - Any other reasonable measures taken to ensure patient protection and privacy

# Potential Professional Liability Claims

Risk Management conducts pre-suit investigations on legal notices of an intent to file a lawsuit, or if in our opinion, an incident has the potential for becoming a lawsuit

- Examples of potential legal cases:
  - Surgical procedure on the wrong site
  - Medication error causing death
  - Retention of a foreign body upon completion of a surgical procedure
  - Delay in administering care resulting in death or other negative outcome

# General Liability Issues

**EQUIPMENT MALFUNCTIONS**

**THEFT**

**SLIP AND FALLS**

**FIRE**

**AUTO ACCIDENTS**

**EXPLOSION**

**PROPERTY DAMAGE**

**VANDALISM**

# To Contact Risk Management

If you need more information or for any questions, please contact your assigned risk manager or the Risk Management Department at:

- JHS: 305 585-2900
- JNMC: 305-654-3199
- JSCH: 305-256-5162

- Risk Manager on call: 305-216-5391


Revised by:
Risk Management
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