Best Practices: The Risk Manager’s Perspective

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Objectives
- Identify risk reduction educational opportunities for staff.
- Identify best practices for risk strategies.
- Review case examples of risk and liability.

What is Risk?
Circa 1687

Noun
- A situation involving exposure to danger.
- Possibility of loss or danger
- Someone or something that creates or suggests a hazard

Verb
- To expose someone or something valuable to danger, harm or loss.
- To expose to hazard or danger
- To incur the risk or danger of.

You risk losing a hand if you take a bone from a dog.

Human error is often unavoidable, unpredictable, and unintentional

Risk management is the process by which vulnerabilities are identified and changes are made to minimize the consequences of adverse patient outcomes and liability.
Risk to Whom?

- Patient/Family
- Staff
- Facility

Finding the Requirements

- CMS
- TJC
- DNV
- HFAP
- OSHA
- CDC
- KY STATUES
- PROFESSIONAL STANDARDS
- EMTALA
- HIPPA
- FACILITY POLICIES

Need to Know

- Chain of Command
- Hand Off Process
- EMTALA
- HIPPA
- Equipment Use
- Documentation Standards
- Environmental Dangers
- Violence in the Workplace
- Sentinel Events
- Completion of Incident Report

Chain of Command - protecting the nurse, patient and the hospital

- Start at the level closest to the patient’s care - Charge Nurse or Head Nurse
- Move up as needed - House Supervisor or Department Director
- Get Administration involved - Chief Nursing Officer, Chief of Services, CEO
A patient with long-standing respiratory issues requiring CPAP for several years has suffered post-surgical complications. Although these respiratory issues are unrelated to the reason for the patient's hospitalization, the issues have manifested during what has become a difficult post-surgery recovery for the patient.

While in the critical care unit, the patient shows clear clinical signs and symptoms of respiratory distress. The responsible nurse notifies a physician, who orders an ABG. That ABG results contain panic values and show a patient in respiratory acidosis. Clinically, the patient’s respiratory status has also worsened.

The responsible nurse again notifies the physician, who refuses to come see the patient and who does not order additional interventions. Rather, the physician simply tells the nurse to monitor the patient.

The patient suffers respiratory failure, codes, and later dies.

Could more have been done? YES!!

What? The RN felt the patient was quickly deteriorating, but did not utilize the chain of command.

Hand-Offs
Real life/Interactive
- Caregiver to Caregiver
- Intradepartmental- Temporary transfer of care
- Change of Shift
- Change in level of care

Patient Identification
- Risk management strategies revolve around using two patient identifiers to verify identity, a basic patient safety rule.
- Some organizations have designated patient identification as a "red rule," meaning the two-identifier rule must be followed without exception or there are defined consequences.
- Encourage patient participation and staff active listening skills.
- Hardwire the practice with a "ticket to ride" or "trip ticket" during patient transport.
CASE

- Radiology is already busy at 8:30 am on a Monday morning. The transporter hurries to get Miss M for a CT. He asks if she is Miss M, receives a positive response and off they go. The patient says she’s not aware of any exams she needs, and the transported assures her this was ordered by her doctor. He hurries to the department, Miss M has her CT and returned to her room. The transporter passes the RN in the hallway, stating “patient is back”. As it turns out the CT was scheduled for the patient two rooms down, Mrs. M.

Hand Off Process

- Standardize the process
- Avoid environmental distractions
- Communication skills
- Train staff to hand-off

EMTALA

- The Emergency Medical Treatment and Active Labor Act is a statute which governs when and how a patient may be
  1. refused treatment or
  2. transferred from one hospital to another when he is in an unstable medical condition

Case Example

- The ER attending physician receives a call from a small rural hospital wanting to transport a 50 y/o male with chest pain to your facility. The rural hospital has done an EKG and performed blood work. Your ER attending denies the transport suggesting that the patient be admitted to the rural hospital for observation. The rural hospital does not have a cardiologist on staff.

  Is this an EMTALA violation?
YES!!

Why??

Under EMTALA, if a hospital does not have the staff or the resources to treat and stabilize a patient with an emergency medical condition, a tertiary care center (or any hospital) who does have the resources, has to accept the patient if requested.

Confidentiality

- Rules cover all forms of communication:
  - MAR (Medication Administration Record)
  - Communication Boards in Patient’s Room
  - Patient Charts
  - Patient Rooms
  - J.T. Ellis N213
  - Dietary Trays
  - Lab slips or specimens
  - FAX

HIPPA - Health Insurance Portability and Accountability Act

- Confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared
- Applies to all forms of PHI, including paper, oral, and electronic, etc.

HIPPA Violation

- In Mississippi where a hospital administrative assistant was forced to resign because hospital officials believed that a tweet she sent to the Mississippi Governor Haley Barbour violated HIPAA regulations.
- According to news reports, the governor wrote on his Twitter page that he was, “Glad the Legislature recognizes our dire fiscal situation. Look forward to hearing their ideas on how to trim expenses.”
- The employee sent a tweet to the governor saying, “Schedule regular medical exams like everyone else instead of paying UMC employees over time to do it when clinics are usually closed.”
Equipment Use & Care

- Adequate training
- Intended use
- Knowledge of proper operation- manufacturer guidelines
- Policies and Procedures related to equipment
- Steps to take if equipment is not functioning properly
- Regular scheduled maintenance and inspection
- Document education and validation of staff

Documentation

- Know policies and procedures
  - based on current and recognized practice
  - updated regularly
  - realistic
- Timing
  - Time and date all entries
  - Update entries to reflect changes in status
- Who, when, why and what
  - Who did you contact
  - When did you contact them
  - Why did you contact them
  - What were the results

Case

- A patient has a hemoglobin level of 6.5 grams/dl (normal, 14 to 18 grams/dl). His clinical information is sent to the insurance company for precertification and his hospital stay is approved.
- A nurse picks up an ordered unit of packed red blood cells from the blood bank and takes it to the patient’s room, but he refuses the transfusion.
- The nurse is called to an emergency and assigns a nursing assistant to return the blood. Caught up in the emergency, the nurse forgets to document the patient’s refusal.

Is there a problem?

- His records indicate that a transfusion was ordered and a charge was generated, but no record of his receiving the blood or refusal appears in the medical record.
- If the hospital bills, it will be seeking payment for a service it didn’t deliver.
- The payer may deny all or part of the payment or it could press fraud charges against the hospital.
Environmental Risks

- Infectious Waste
- Hazardous Materials
- Pharmaceutical Waste
- Blood Borne Pathogens
- Internal Environment
- Drug Resistant Organisms

How Risky is Our Business?

2010 Labor Department Statics - injuries per 100 workers

- Mining -- 2.3
- Construction -- 4.0
- Manufacturing -- 4.4
- Hospitals -- 7.0
- Nursing and Residential Facilities -- 8.3

Violence in the Workplace

- National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as any physical assault, threatening behavior or verbal abuse occurring in the workplace.
- Violence includes overt and covert behaviors ranging in aggressiveness from verbal harassment to murder.

Fatal Occurrence

From 2003 to 2009, 8 registered nurses were FATALLY injured at work
- 4 RNs received gunshot wounds (RNs) leading to their death
- 4 RNs received other fatal injuries
- 8 of 8 RNs were working in private healthcare facilities (not state or local government)
- 8 of 8 RNs were 35-54 years of age
Violence in the Workplace

- Perform an employee survey about their fears and feelings
- Consultants to identify potential risks for staff, employees and patients
- Include in orientation and yearly education

Sentinel Events

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.
- Such events are called “sentinel” because they signal the need for immediate investigation and response.
- The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events

Reviewable Sentinel Events

- Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error
- A patient commits suicide within 72 hours of being discharged from a hospital setting that provides staffed around-the-clock care
- Any elopement, that is, unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function
- A hospital performing the wrong invasive procedure or operating on the wrong side, wrong site or wrong patient
- Any intrapartum (related to the birth process) maternal death

Reviewable Sentinel Events

- Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
- A patient is abducted from the hospital where he or she receives care, treatment, or services
- Assault, homicide, or other crime resulting in patient death or major permanent loss of function
- A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- Hemolytic transfusion reaction involving major blood group incompatibilities
- A foreign body, such as a sponge or forceps, that was left in a patient after surgery
**JC Sentinel Event Data**

- 2012 (N=901)
  - Human Factors 614
  - Leadership 557
  - Communication 532
  - Assessment 482
  - Information Management 203
  - Physical Environment 150
  - Continuum of Care 95
  - Operative Care 93
  - Medication Use 91
  - Care Planning 81

**Incident Reports**

- Complete when a variance or near miss occurs; including staffing concerns, equipment problems, professional practice or behavior.
- Just the facts, no opinions or analysis, what was seen and heard
- Don’t mention the IR in the patient’s MR

**Incidents**

- Help to identify organization and system flaws
- Allow the opportunity to improve and lessen the risk of future incidents
- Provide educational value and opportunity for all

**Take Away**

- Provide staff with the tools to protect themselves, their patients and the facility.
- Provide education on new processes.
- Be proactive to identify risk potentials.
- Promote a Culture of Safety and encourage staff involvement is helping to identify risks.
Thank You for Your Attention